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TO EXAMINE THE COST AND AVAILABILITY OF HEALTH CARE BENEFITS FOR SMALL BUSINESSES AND PROPOSALS FOR FEDERALLY MANDATED HEALTH BENEFITS

HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

TO

EXAMINE THE COST AND AVAILABILITY OF HEALTH CARE BENEFITS FOR SMALL BUSINESSES AND PROPOSALS FOR FEDERALLY MANDATED HEALTH BENEFITS

APRIL 23, 1987

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April 23, 1987:
- Morning session 1

TO EXAMINE THE COST AND AVAILABILITY OF HEALTH CARE BENEFITS FOR SMALL BUSINESSES AND PROPOSALS FOR FEDERALLY MANDATED HEALTH BENEFITS

THURSDAY, APRIL 23, 1987

U.S. SENATE,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m., in Room 428A, Russell Senate Office Building, Hon. Dale Bumpers (Chairman of the Committee) presiding.

STATEMENT OF HON. DALE BUMPERS, A U.S. SENATOR FROM THE STATE OF ARKANSAS

Senator BUMPERS. The Committee scheduled this hearing so that Senators and the public alike may examine the problems related to the cost and availability of health insurance for small businesses and their employees.

In 1987, millions of Americans find themselves with no health insurance and the blessings of American medicine out of their reach. Estimates vary from 28 to 35 million individuals under 65 with no health coverage, but even the lower figure is a national disgrace. Especially disturbing is the fact that 11 million of the uninsured are children age 18 and under.

For the truly destitute there is Medicaid, but for millions of working Americans there is no protection from easily overwhelming costs of illness and especially hospitalization. This situation is clearly unacceptable, especially because we have evidence that the lack of health insurance does limit access to health care.

A 1983 study found that in the preceding year, 3.9 million families reported there had been times in the previous year when they or someone in their families needed medical care but did not obtain it. And the overriding obstacle to getting the care they needed was financial. Moreover, the evidence is clear that when treatment is delayed, the costs, both financial and human, increase drastically. Most worrisome is the fact that a significant portion of those without health insurance are employed by small firms.

Fewer workers in small firms are covered by the employer's health plan than workers in large firms and we will hear testimony today on this issue. Because of those numbers, policymakers have to consider the small business community in fashioning solutions to the problems of health insurance coverage.

This Committee is concerned, however, that remedies fashioned in Washington not cause the loss of jobs on Main Street in America. Just as it is unthinkable for a person to give up his or her job in order to be eligible for Medicaid in the event of a serious illness, we in Congress must insure that the proposals to mandate that health coverage be provided do not sink hundreds of small businesses and the jobs they provide.

The Committee has heard from many small business owners who are convinced that legislation mandating health insurance coverage for employees will force them out of business, and we want to investigate the issues they have raised.

Let me say that in my view this is not a problem of greed by small business owners who would pocket profits rather than give health coverage to their employees. It is a problem of cost and to some extent availability.

This hearing is intended to lay out the current situations from the perspectives of small businesses seeking to provide health insurance policies and insurers who attempt to serve the small business market.

We will also hear from witnesses who have developed innovative new strategies for providing affordable health insurance to small businesses. We hope to find ways to encourage and replicate their success across the country.

It is crucial that any legislative solution offered really addresses the small business problem. Data from a new study from the Small Business Administration will be unveiled today and will help us identify precisely small business health insurance problems and will be very important in helping us design remedies to assist the most vulnerable part of the small business community.

The information Frank Swain will present reinforces my belief that the first thing we have to do, and it is long overdue, is increase the tax deduction allowed unincorporated sole proprietorships for their purchase of health plans. The Senate's Tax Reform Bill last year provided for 50 percent deductibility for small business owners and farmers. Yet the final Conference Report allowed only a 25 percent reduction of this cost by the self-employed. Businesses with one to nine employees are least likely to offer insurance to their employees because they have the most difficulty finding affordable coverage. It is possible that we will have to provide additional tax incentives or financial assistance to these employers and their employees if they are to improve their health insurance coverage and stay in business.

We need also to look at innovative approaches that are being developed by States, cities, towns, and private organizations. They are showing much more creativity in addressing this issue than is the Federal Government. Florida, West Virginia, Wisconsin, Arizona, and several other States are investigating ways to improve coverage among small businesses and low-income workers.

The 15 programs funded by the Health Care for the Uninsured Program of the Robert Wood Johnson Foundation, including State efforts, hold great promise. These efforts range from organizing multiple employer trusts to the development of a health insurance information and referral service for small businesses. Most of these efforts are in planning and early implementation stages, but I certainly hope that some of these innovators could appear before the Committee at a later date.

This hearing and perhaps others will go a long way toward helping legislators understand the unique problems of small businesses and I hope be equally beneficial to small business owners in finding creative solutions to the problem of affordable health care.

Senator Dixon, do you have an opening statement?

Senator Dixon. Mr. Chairman, I have an opening statement but I will place it in the record in the interest of time. I thank the Chair.

[The prepared statement of Senator Dixon follows:]

APRIL 23, 1987

STATEMENT BY SENATOR ALAN J. DIXON

COMMITTEE ON SMALL BUSINESS

HEALTH CARE BENEFITS

MR. CHAIRMAN, I WANT TO THANK YOU FOR HOLDING THESE HEARINGS ON AN ISSUE OF SUCH IMPORTANCE. MANDATED HEALTH BENEFITS AND THE AVAILABILITY OF HEALTH CARE ARE OF INTEREST TO A GREAT

MANY PEOPLE--TO EMPLOYERS AND EMPLOYEES IN BOTH LARGE AND SMALL BUSINESS. THE PROVISIONING OF HEALTH PLANS, THE SPIRALIING COSTS, THE BURDEN OF PAYING FOR HEALTH INSURANCE AND THE GOVERNMENT'S ROLE IN THESE ISSUES NEED TO BE EXAMINED.

THERE ARE APPROXIMATELY 37 MILLION UNINSURED PEOPLE IN OUR COUNTRY, 54% OF WHOM ARE EMPLOYED BY SMALL FIRMS. COVERAGE OF THOSE UNINSURED WILL INDIRECTLY IMPACT THE COST OF DOING BUSINESS FOR MANY SMALL AND LARGE FIRMS.

ONLY 45% OF THE SELF EMPLOYED ARE COVERED BY A HEALTH PLAN AND PART TIME WORKERS ARE RARELY COVERED BY EMPLOYER PROVIDED HEALTH INSURANCE PLANS. OFTEN TIMES THE SELF EMPLOYED OR PART TIME WORKER IS COVERED UNDER THE HEALTH PLAN OF A FAMILY MEMBER OR SPOUSE WORKING FOR A LARGER FIRM. THIS PUTS A BURDEN ON THE LARGER FIRM'S HEALTH PLAN.

THERE ARE MANY COMPLEX ISSUES, WITH FAR REACHING IMPLICATIONS WITHIN THE SUBJECTS THAT WE WILL DISCUSS HERE THIS MORNING. THE FIRST AND MOST OBVIOUS IS AN UNDERSTANDING OF THE TERM MANDATED. IN ORDER TO DEFINE THE

SUBJECT, WE MUST FIRST DEFINE THE TERMS. ARE WE TALKING ABOUT MANDATING THAT ALL EMPLOYERS PROVIDE ACCESS TO HEALTH PLANS; THAT ALL EMPLOYEES BE MANDATED TO PARTICIPATE IN THEIR EMPLOYER'S BENEFIT PLAN, AS A CONDITION OF EMPLOYMENT; THAT MINIMUM BENEFIT STANDARDS BE MANDATED OR SOMETHING ELSE?

WE THEN HAVE TO DEAL WITH THE ISSUES OF HOW THIS WILL IMPACT BUSINESS--SMALL AND LARGE. SMALL BUSINESS BEARS A HIGHER COST PER EMPLOYEE FOR HEALTH INSURANCE, SO WE NEED TO EXAMINE ALTERNATIVES SUCH AS THE MULTI-EMPLOYER PLANS, POOLING OR ASSOCIATIONS

OF SMALL BUSINESSES FOR HEALTH PLAN PURPOSES AND INCENTIVES.

I AM AWARE THAT THERE IS A GREAT DEAL OF OPPOSITION TO MANDATED BENEFITS. THIS OPPOSITION IS THE SECOND PRIORITY OF THE WHITE HOUSE CONFERENCE ON SMALL BUSINESS AND IT IS THE NUMBER ONE PRIORITY OF THE SMALL BUSINESS LEGISLATIVE COUNCIL. THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS ALSO OPPOSES MANDATING BENEFITS.

GIVEN THE IMPORTANCE OF THESE ISSUES AND THEIR IMPACT ON THE LIVES OF INDIVIDUALS, BUSINESS, AND THE ECONOMY, I AM VERY INTERESTED IN THE TESTIMONY THAT WE WILL HEAR THIS MORNING. KEEP IN MIND, THOUGH, THAT THESE DISCUSSIONS DO NOT ADDRESS THE WHOLE PROBLEM. WE ARE ONLY FOCUSING ON THE EMPLOYEE/EMPLOYER ROLE IN HEALTH INSURANCE. THIS DOES NOT ADDRESS THE NEEDS OF THOSE NOT IN THE LABOR FORCE.

IN CLOSING, MR. CHAIRMAN, I WOULD AGAIN LIKE TO THANK YOU FOR HOLDING THESE HEARINGS, AND THANK EACH OF THE WITNESSES FOR TAKING THEIR TIME TO PROVIDE US WITH THEIR VIEWS ON THESE COMPLEX ISSUES.

Senator BUMPERS. Thank you very much, Senator.

This morning, our first witness will be Mr. Frank Swain. Mr. Swain is Chief Counsel of the Office of Advocacy, U.S. Small Business Administration. Welcome, Frank, and please proceed.

STATEMENT OF FRANK SWAIN, CHIEF COUNSEL, OFFICE OF ADVOCACY, U.S. SMALL BUSINESS ADMINISTRATION, WASHINGTON, DC

Mr. SWAIN. Mr. Chairman, thank you very much and our congratulations to you and the members of the Committee.

Health care is really a key issue for small businesses in this Congress and I think it is very worthwhile for the Committee to dedicate this significant time and attention to this issue. I note that there has been a lot of talk about various aspects of health care legislation but this is in fact the first time that any Committee in Congress has seen fit to focus exclusively and specifically on the important implications of all these discussions toward small businesses.

If it is appropriate, Mr. Chairman, I would like to summarize my statement——

Senator BUMPERS. It is always appropriate to summarize. [Laughter.]

Mr. SWAIN. All right.

Senator BUMPERS. I usually give that admonition in the beginning but nobody ever does it, so I've quit even suggesting it. I am really pleased that you did this on your own.

Mr. SWAIN. Well since I suggested it, I will go ahead and summarize it——

Senator BUMPERS. I listen more carefully when you speak extemporaneously.

Mr. SWAIN. Mr. Chairman, I think it is important to note, first of all, that most small businesses do offer health insurance as a fringe benefits. Except for vacations, health insurance is the most commonly offered fringe benefit by employers to employees. In order to attract and retain employees, employers strive to establish health care plans. The increased knowledge of health care and its importance to small employers is exemplified by the ranking of this issue as second among all recommendations at the White House Conference on Small Business. Only the issue of liability, property and casualty insurance outranked the health insurance issue in the interest of small businesses at the White House Conference.

There are three concerns that make health care an issue of highest importance to small firms. First, how can small employers provide affordable health benefits for themselves and their workers in an era of rising costs? Health expenditures in the United States have increased from $42 billion in 1965 over tenfold to $425 billion in 1985. Health care expenditures comprised almost 11 percent of the GNP in 1985 and that growth has continued well beyond the rate of inflation. So whenever we are talking about an expansion of health care, we are talking about an increase in health cost. Medical prices increased by almost 8 percent, while the inflation rate was 1.1 percent in 1986.

In 1986, health care costs averaged 8 percent of payroll, for an average employer outlay of $1,500 per employee. All employers—especially small employers who experience higher than average costs—are interested in keeping costs down, while providing quality health benefits.

Second, changing demographics will heighten the importance of affordable health plans to small business. Small business and large businesses and employers of every sort have been in a fairly happy later climate, so to speak, for the last several years. It has been a buyer's market, there have been a lot of people out there seeking jobs, many more than people that have been creating jobs. This is going to get turned around; our demographics are changing and through the rest of this century the labor market is only going to be growing at 1 percent a year. As the growth of the labor supply slows and there are fewer workers available, health benefits will be an important tool in helping small employers to keep their most qualified labor.

Finally, and certainly driving much of the discussion of health care benefits in this country today, there is a growth in the medically uninsured population in this country. Attention has focused on expanding employer health benefits as a policy response to cover many of the people that now have no health insurance whatsoever. Small businesses are at the center of this focus because most of the working uninsured are indeed employed in these small businesses.

We have a chart, Mr. Chairman, that we provided in the statement and a copy is on the easel there. We estimate that there are approximately 32 million uninsured individuals in the United States. Approximately 8.2 million of that 32 million, or about one fourth, are private sector, non-farm, wage-and-salary workers who are employed all or part of the year. In other words, one fourth of the people who do not have any insurance work, the majority of the remaining three fourths of the people do not work, either because they are unemployed, or because they are non-workers such as dependents, and they do not have health insurance. And of the 8 million who work, 6 out of 8 million, or three fourths of those individuals, are working in firms with fewer than 500 employees. The majority of insured small firm employees are found employed in the very smallest companies that have less than 25 employees. To the extent that statements are made that we have a terrible problem in this Country with an uninsured population and that we could solve this problem by forcing all businesses, especially all small businesses, to purchase health insurance for their workers, that simply is not an adequate solution.

Senator DIXON. Could I interrupt, Mr. Chairman? I apologize. Senator Nunn had called me out of the room for a moment and I missed that first part.

Now you were saying a certain percentage do not work at all, would you repeat that for me?

Mr. SWAIN. Yes, sir. Of the 32 million uninsured, 8 million of the 32 million are private wage-and-salary workers. The majority of the balance, 24 million, do not work.

Senator DIXON. So only a fourth of them actually are employed people?

Mr. **Swain**. That is right. This excludes the approximately 4 million business owners and Government, farm, and household workers. And if you have mandated insurance—if every employer were purchasing, either because they chose to or because some law required it, health insurance for their employees, you would guarantee obviously to some degree coverage of those 8 million workers, although we would argue, as we will in a moment, that there would be such a cost that not as many people would be working and so you might have some drop off that way.

But beyond that, 8 million people would be covered. Some proportion of the others would probably be covered because they represent to some degree dependents of the 8 million who are working. But there still would be a large group of people that are either unemployed or laid off, or retired but not over 65 yet, that still would not have coverage.

Senator **Bumpers**. Frank, if I may just interrupt at that point also.

(To Senator Dixon.) Your question is appropriate.

It is my understanding that while there are 32 million people who have little or no coverage all year long, there are millions more who have no coverage for part of the year. Do you have statistics that support that?

Mr. **Swain**. To be honest, Senator, no, I have not. I would say that it is certainly conceivable that the 32 million figure is not a constant figure because there is a large flux in the market.

Maybe I should just get to my next point, which is that most of the people who are uncovered in small businesses are uncovered in two particular industries, construction and retail trade. Within those industries, they tend to be the very smallest employers, employers with fewer than 25 workers. Those are industries which in many cases are seasonal, employment has great fluctuations, and the cash-flow and profitability have great fluctuations. Indeed, there are a lot of either seasonal or temporary employees in this country and whether they are covered or not is a major issue.

There may well be at given points in time a lot more than 32 million uncovered individuals. I myself have not seen the 65 million figure, however, this is our best estimate of the uninsured and there may be other people that have higher levels of information on it.

Senator, I am sorry——

Senator **Dixon**. No, you took care of my concern.

Mr. **Swain**. OK. At any rate, of the working uninsured, as we mentioned, 6 million are in firms with under 500 workers, with the majority employed in the smallest companies of fewer than 25 employees. So to the extent that employers do not buy insurance for their workers, most employers do but those who do not tend to be in the very smallest firms. It is not something broad across the board. To paraphrase Senator Bumpers' opening statement, small businesses do not fail to cover their workers because they are cheap, rather because they tend to be very small and their businesses tend to be less viable, their cash flow tends to be more volatile, their employment patterns tend to be more volatile and it is just more expensive and more difficult to cover these people.

The key question of course is who should pay for some increased level of coverage? Providing minimal health coverage to every medically uninsured person in this country would cost upwards of $20 billion, which is a fairly conservative figure. The hard issue facing us if we want to cover all or a major part of these people, is who pays for that cost? The choices lie among employees, beneficiaries or the government. Employer-sponsored plans have burgeoned since World War II when they began to receive favorable tax treatment. While the employer and workers pay for health costs, they are subsidized by Federal tax rates to the extent the employer deducts health benefits as business expenses and excludes health plan contributions from employee payroll and income taxes.

At the same time, employers and workers pay a considerable share of income and payroll taxes for Government health programs, principally Medicare and State Medicaid. In addition, there has been a trend to shift beneficiary responsibility away from the Government and on to employers. In fiscal 1987 alone such additional costs to employer plans were estimated at $1.8 billion in benefit payments, plus an additional amount in administrative costs. For example, employers with health plans are now the primary payer, rather than Medicare, of elderly workers and elderly spouses. Under the 1985 Budget Bill, the so-called COBRA employers are also required to continue to offer health insurance to employees who leave, widows, divorced spouses and certain dependents.

Just as an aside if I may, Mr. Chairman, some people asked why are the delegates to the White House Conference so exercised about health issues? They went to their State conference and it really did not receive too much attention. And that is true, most of the state conferences did not focus on health insurance.

First, the work last year on the family or parental leave bill that included continued employer-sponsored health insurance, about mandates got people more excited than they had been previously, a number of people suggested to me that the COBRA amendments which I just described that require employers to offer continuing coverage to their employees and were effective last July 1. So around July 1st, employers that were covered by COBRA started getting notices from their accountants or insurance carriers saying that the Government requires you now to provide this coverage which you never had to provide before. There was such a natural antipathy to this largely unknown, unanticipated, unrequested government mandate that it welled up and all of a sudden we find as our number two small business priority no Government mandated health policies whatsoever. That is largely because of the immediate effectiveness of COBRA last July 1 and the COBRA notices going out. Although COBRA in the scheme of things is very modest compared to proposals for mandated general coverage, it certainly was enough to get the small business community pretty aggravated.

The debate for employer plan expansion has centered on two approaches: mandating such coverage or creating voluntary incentives to encourage expansion. There is a strong consensus within the small business community to oppose any type of mandate, for reasons which we detail. After careful examination of the nature of the kinds of firms that lack coverage and the characteristics of medically uninsured workers, I suggest that we rethink the type of coverage that is expected of and available to employers and employees. Unlike any mandate proposal, developing and broadly marketing a catastrophic health insurance plan could significantly lower costs to the point where small employers without health plans would voluntarily purchase such insurance.

We really think that the remedy is not by Government mandates. Or if it ever lies with Government mandates it is far too premature to suggest a mandate right now. We have not begun to explore various voluntary means of getting most small employers more interested in health insurance. Nor have we, I think, begun to seriously explore various options, some of which may involve deregulation at the Federal and more likely the State level of the laws that govern the types of policies that insurance companies can sell. Insurance companies may well be able to sell a more bare bones, less expensive policy to small employers and employees.

Nor, as your opening statement suggests, have we gone anywhere as far as we could go in tax incentives, particularly for sole proprietorships. All of our evidence indicates that they are the ones that most likely have no health insurance.

STATEMENT OF HON. CHRISTOPHER S. BOND, A U.S. SENATOR FROM THE STATE OF MISSOURI

Senator **Bond**. Mr. Chairman, excuse me, may I interrupt just to express my apologies. I have another meeting. I appreciate Mr. Swain's testimony. I have a brief statement and with your permission I would like to submit to the record some questions.

Senator **Bumpers**. Without objection the statement will be entered in the record.

Senator **Bond**. Thank you, sir.

[The prepared statement of Senator Bond follows:]

Thank you, Mr. Chairman, for convening this hearing on such a timely and important matter to the small business community.

I SPOKE WITH MANY REPRESENTATIVES OF SMALL BUSINESS LAST WEEK AS I TRAVELLED THROUGH THE STATE AND I HEARD ONE CONSTANT REFRAIN: "IF YOU WANT US TO BE COMPETITIVE, DON'T SADDLE US WITH MORE GOVERNMENT REGULATIONS".

THE EFFORT TO IMPOSE NEW REQUIREMENTS ON SMALL BUSINESS, LIKE MANDATED HEALTH BENEFITS, SEEMS PARTICULARLY IRONIC IN LIGHT OF OUR EVER-GROWING TRADE DEFICIT AND THE NATIONAL DEBATE ABOUT REGAINING OUR INTERNATIONAL COMPETITIVENESS.

SMALL BUSINESSES IN RURAL AREAS WOULD BE ESPECIALLY HARD HIT. MANY OF THEM ARE STRUGGLING TO SURVIVE IN AREAS DEVASTATED BY THE AGRICULTURAL CRISIS. WE NEED TO MAKE IT EASIER, NOT HARDER, FOR THESE SMALL COMPANIES TO STAY IN BUSINESS. FURTHERMORE, WE NEED TO FOSTER CONDITIONS WHICH ENCOURAGE NEW BUSINESSES TO LOCATE IN THESE ECONOMICALLY MARGINAL AREAS. MANDATING BENEFITS WOULD CLEARLY DISCOURAGE THE FORMATION OF NEW BUSINESSES AND THE EXPANSION OF CURRENT ONES.

ALL THESE PROPOSALS - MANDATED HEALTH INSURANCE, MANDATED PARENTAL LEAVE, THE MINIMUM WAGE INCREASE - ARE SOCIALLY WORTHY. HOWEVER, THEY ARE BEST ADDRESSED BY INDIVIDUAL SMALL BUSINESS OWNERS ON A VOLUNTARY BASIS. THEY INCREASE THE COST OF DOING BUSINESS AND MAKE SMALL BUSINESSES LESS COMPETITIVE WITH THEIR COUNTERPARTS ABROAD.

Thank you, Mr. Chairman.

QUESTIONS FOR FRANK SWAIN
FROM SENATOR CHRISTOPHER BOND

1. From your survey results, can you tell us what kinds of small businesses currently offer health insurance to their employees? What factors influence them to do so?

2. If legislation is drafted requiring all companies to offer health insurance coverage to their employees, what special consideration should be given to small businesses? For example, should companies under a certain number of employees be exempted or only required to offer a limited health insurance package? Should the tax code be amended so self-employed individuals and unincorporated businesses can deduct 100% of their cost of health insurance premiums instead of the 25% currently allowed. (Incorporated businesses are allowed to deduct the full cost of premiums.)

3. The problem of providing health care to uninsured individuals is a real one. Are there some other solutions to this dilemma which aren't so burdensome to small business?

U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

OFFICE OF CHIEF COUNSEL FOR ADVOCACY

June 3, 1987

Honorable Dale Bumpers
Honorable Lowell Weicker, Jr.
United States Senate
Committee on Small Business
428-A Senate Russell Office Building
Washington, D.C. 20510

Dear Senators Bumpers and Weicker:

The following answers are in response to questions submitted by Senator Bond and Senator D'Amato for the April 23 hearing on small business and health care.

CHARACTERISTICS OF SMALL EMPLOYERS WITH HEALTH COVERAGE

For competitive reasons, all employers are interested in providing health benefits to attract and retain employees. Health care is second only to vacations the most common fringe benefit. The kinds of small firms that offer health care coverage to workers tend to be all but the very small: over 90 percent of employers with over 25 employees offer coverage, compared to 78 percent of firms with 1-24 employees, or 46 percent of firms with fewer than 10 employees. Firms which lack insurance are mostly in retail trade, construction, and certain services. Approximately 70 percent of companies in other industries offer coverage. Small firms with plans experience higher and more stable profits. For example, small businesses that are likely to join an association or Chamber of Commerce are more likely to be able to afford to purchase health care. Moreover, relative to small firms without coverage, small firms with coverage, in general, have more stable workforces, i.e., lower turnover, fewer temporary, seasonal, or part-time workers.

SMALL BUSINESS EXEMPTIONS UNDER A MANDATE

As you know, the small business community remains overwhelmingly opposed to employer-mandated health coverage. Legislative proposals that I have seen would not lower the cost of health care to small firms, which is the principal problem faced by employers not presently offering this benefit. Insufficient profits was the number one reason cited by small employers who did not offer coverage. An exemption for small businesses of fewer than 25 employees would definitely help these firms who are least able to afford the cost of a mandate; however, these companies also employ about one-half of all uninsured workers. Therefore, proponents of a mandate are not likely to support any exemptions for small business.

VOLUNTARY ALTERNATIVES TO EXPAND COVERAGE IN SMALL FIRMS

My testimony included four policy recommendations for expanding coverage in small firms through voluntary incentives. These include extending the tax deduction from 25 to 100 percent for unincorporated business owners; encouraging development of a private catastrophic (low-cost) health plan through a limited Federal preemption of state mandates; examining the success and transferability of the 15 state programs currently underway that focus on assistance to uninsured small firms and low-income workers; and fostering education and promotion programs through the government and the private sector.

I would be happy to more fully discuss these options with you or your staff. Please do not hesitate to call me or Patricia Powers of my staff at 634-6115.

Sincerely,

Frank S Swain

Frank S. Swain
Chief Counsel for Advocacy

Senator BUMPERS. Proceed Mr. Swain.

Mr. SWAIN. I'll maybe just briefly go through three more charts, Mr. Chairman. This chart indicates the percentage of firms that offer health benefits. Almost 100 percent of large businesses offer health benefits. I frankly do not expect to see a whole lot of large businesses up here fighting the good fight against mandated coverage because they mostly offer it now, therefore, it is not a big issue to them.

There is some dropoff, but as you can see the really big dropoff is 80 percent of the firms with over 25 employees offer health coverage, but less than 50 percent of the firms with under 25 employees do so. It is really what some people might call a micro business problem; the really small businesses are the ones that do not offer coverage to their employees.

Now why is this the case? Data indicate that premiums in small companies run 10 to 15 percent higher in small firms than large firms. Certainly administrative costs are higher as well. In fact, you may have noticed in the Washington Post, I believe on Monday, there was an article that right here locally Blue Cross-Blue Shield was going to raise their rates for most small employer premiums 70 percent. It is really a cost issue for small firms and I think that is illustrated by the fact that when we asked the question as to why most small employers did not cover their workers the major answer given was profitability.

When you begin to look at the kinds of firms that do not have insurance, they tend to be retail firms—in fact 40 percent of all the firms that do not have any health insurance are retail businesses with fewer than 10 employees. These are the Main Street businesses with eight or nine workers, the cigar store, the newspaper stand, and so forth—Mom and Pop businesses.

Most of the firms tend to be in the retail or construction businesses, they are the ones that are the most volatile and they are the ones that have temporary employees. It is more expensive to cover these people, their health records are perhaps judged a little bit more apprehensively by carriers and certainly the administrative costs are a lot higher as well.

Senator BUMPERS. I am looking at the chart on page 13 of your prepared statement.

Mr. SWAIN. Yes, sir.

Senator BUMPERS. And it looks like about 30 percent of the total retail firms offer coverage. But does your data provide a breakdown of coverage by retail firms, based on size of the firm? If you are talking about a K-Mart or Sears or Wal-Mart, I'd imagine they offer their employees coverage.

Mr. SWAIN. Absolutely. In fact, the chart indicates, Senator, two bars that represent two size categories. The bar with the stripes in it is retail firms with under 100 employees——

Senator BUMPERS. OK.

Mr. SWAIN [continuing]. And the solid bar is over 100 employees. So 95 percent of Wal-Mart and K-Mart type firms offer coverage. With under 100 employees, 30 percent of the firms offer coverage. It is that way across the board.

I might just add a footnote that transportation, as it indicates, is actually a combination of agriculture and mining as well. On these data or any of the figures that we have, if you would like more information we would be happy to give them to you. We did a little bit of summarizing for purposes of the statement.

Our next chart, Senator, on page 14, likewise I think illustrates the problem. The three bars in each of the categories are the legal forms of business organizations. As you can see in nearly every category, corporations or subchapter S organizations, which as you know, is in effect a corporation with partnership tax consequences, generally offers much higher levels of health coverage than sole proprietorships. That is particularly dramatic in the very smallest size categories. Again, even in the smallest categories, corporations with less than 10 employees, have a 70 percent likelihood of offering those employees health insurance. That makes sense. If I am the president of a corporation and I hold all the stock in the corporation, I pay myself a salary, I pay my workers a salary, and I have a health plan for which I can deduct the total cost of that health plan as a corporation. As a sole proprietorship, until this current year that we are in now, I could not deduct anything for myself. If I was the owner/operator of my business and I hired eight other people, I could buy insurance for them and deduct it as a business expense, but if I put myself as part of that employer health plan, I could not deduct the premiums that I paid for myself because of the tax laws.

As Senator Bumpers' opening statement noted, there was a modest change this year. For the first time the owner/operator, the sole proprietor, can deduct 25 percent of health premiums for him or herself as a tax deduction. That was brought down from the Senate proposal of 50 percent. The House had no similar proposal and in conference it was compromised at 25 percent.

Senator **Dixon**. If I may interrupt, Mr. Chairman, what is the state of the law on that now? Can a corporate entity, even a small one, where the owner of the corporation, has all the stock, still deduct all of his insurance?

Mr. **Swain**. Yes, as long——

Senator **Dixon**. That is the state of the law even now?

Mr. **Swain**. Oh, yes. Now the Tax Reform Act does have non-discrimination provisions that apply to both pension and health care. There are some formulas to make sure that pension plans are not top heavy, that is, highly compensated individuals make very generous deductions for themselves and not as generous for other people.

Senator **Dixon**. I just want to observe, Mr. Chairman, looking at this chart it is quite obvious that 70 percent of the corporate entities, the small ones, do deduct because of the advantage the stockholder—the owner has, whereas it is under 30 percent in a sole proprietorship situation. It is a pretty dramatic piece of evidence.

Senator **Bumpers**. Yes.

Mr. **Swain**. I want to say, Mr. Chairman, obviously I am not the Treasury Department, I am not here to tell you what the revenue consequences are, but from a small business health policy perspective, I think as you just said, the conclusion is inescapable. The differing tax treatment, depending on whether one owns one's business as a corporation or as a sole proprietorship makes all the difference in the world for those eight or nine workers that they employ in that business, as to whether there is health coverage offered or not.

Finally, we make note, Mr. Chairman, that small firms are disproportionate employers of the very young, the very old, women, and part-time workers. Large firms generally have an employment profile that is much more male, middle aged, middle income. People that are at either end of the work force, either just coming into it or just going out of it, tend to be employed by the small firms. That is another reason that the health care issue is so difficult for small firms. If you tend to employ a lot of older workers, your health care costs are quite likely to be higher. If you go to a carrier, the carrier might not be quite as enthusiastic about covering that work force.

We have had several examples given to us from employers who tend to employ a lot of younger workers. Those folks are not particularly interested in health care coverage and they will take their chances if they find that there is going to be a major set of deductions from their salary that they would rather not have.

Just because these people are not covered does not indicate that small firms are cheap. Employees may find it difficult to establish coverage. If a significant percentage of workers turn down coverage, a small employer may be unable to obtain a health package from any carrier, or costs for remaining employees are prohibitive. For those reasons we feel that the effects of a mandate would be absolutely staggering.

Our study revealed that the number one reason employers cited as to why they did not offer insurance was insufficient profits. A mandate does nothing to help these firms out. In addition, other entrepreneurs contemplating going into business may be discouraged from doing so because of the cost of starting up and employing people.

Small businesses can be expected to pay for a mandate by shifting costs to consumers by raising prices where possible or to workers by reducing wages. But lower and minimum-wage employees' compensation can only be reduced so far, and we feel that the employment consequences of a mandate would be less employment. It is just as simple as that.

In fact, a quite well known health expert, Uwe Reinhardt from Princeton, who has done a paper that is going to be presented next week at a seminar here in Washington, is forthright by stating that mandated benefits are a tax on employment and on entrepreneurship.

A fundamental problem with mandated benefits is that there has really been no cost figure suggested. I certainly hope that if legislation is going to be introduced there would be a cost figure attached. We do not know how much it is going to cost and small business employers cannot accurately predict what the reaction is without any figures on how much the mandate for a particular type of coverage would cost.

As I mentioned earlier, we do feel that there are a number of voluntary policy options available before anyone should feel that the only way to solve this problem is to resort to a health insurance mandate. The focus should be on voluntary incentives that are likely to increase employers' coverage. First, we feel that there should be promotion of private catastrophic insurance for the general population, which is really not readily available now. By establishing low premiums with high deductibles and specified core benefits, it may be possible to lower costs to the point where small employers will voluntarily purchase such plans.

Initiatives designed to increase the coverage of these workers currently uninsured may also need to include provisions for assisting low income workers with high deductibles. There are a couple of States that are experimenting with Medicaid provisions, allowing low-income workers to buy-in to some degree. I think certainly the experience in those States will be carefully watched and we may have some good examples that we can replicate around the country.

And finally, as a small business advocate, I do urge expansion of the current 25 percent tax deduction for unincorporated business owners to the 100 percent deduction allowed for corporate owners. There is simply no legal or health policy or small business policy reason for that differential. There may be revenue reasons and there are other people in Government who I understand will raise those concerns, but from a small business perspective we think that party is pretty important.

We feel that the voluntary approach, coupled with some increased tax incentive, will do much to solve the problem of having a number of uninsured workers in small firms. We would urge the Congress to look at those approaches to the problem rather than toward any Federal mandate where nobody is precisely sure what the impact would be on the business population. Small business people, however, believe that the impact would be devastating.

I might close with just one comment, Mr. Chairman. Earlier this week I was talking to an accountant from the Midwest who has a large small-business clientele and I asked him, at what point are these costs becoming too much? I said what do you now tell a client who comes in, and what degree do you estimate the cost of health care mandate would be? He said, well I do not know what the cost of such a mandate is, but I will tell you what I am starting to tell my clients. If their business is expanding they ought to figure out how to expand their business without adding any employees. He said the cost of adding an employee is getting so much now that we are counseling our people to contract out, to out-source, to add part-time people, to use independent contractors, to do anything that they can in order to avoid putting a person on a payroll. Because now it costs a whole lot more to put a person on the payroll. If the mandated health coverage is enacted, he noted that is going to be boilerplate advice from our firm, rather than just occasional.

Mr. Chairman and members of the Committee, I thank you very much for your interest and I will be happy to respond to any questions. I also note that our research upon which this testimony is based is being released today. There is a research summary and we have provided Committee members with a full report.

Senator BUMPERS. Thank you very much, Mr. Swain.

[The prepared statement of Mr. Swain follows:]

U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

OFFICE OF CHIEF COUNSEL FOR ADVOCACY

STATEMENT OF

FRANK S. SWAIN

CHIEF COUNSEL FOR ADVOCACY

U.S. SMALL BUSINESS ADMINISTRATION

BEFORE THE

COMMITTEE ON SMALL BUSINESS

OF THE

UNITED STATES SENATE

ON

"NEW DIRECTIONS FOR SMALL BUSINESS AND HEALTH CARE"

APRIL 23, 1987

Mr. Chairman, and members of the Committee, I am pleased to be a part of this hearing on small business and health care. This issue has been a priority for the U.S. Small Business Administration's Office of Advocacy for the past few years and it appears that 1987 is a key year for health care proposals that would significantly affect small firms. I appreciate the opportunity to present new research data today that can be used to evaluate some of these policy alternatives in terms of small business, and I commend you for holding the first hearing on this topic.

THE IMPORTANCE OF HEALTH CARE TO SMALL BUSINESS.

Except in firms of fewer than 10 employees health benefits are the most common fringe benefit offered by employers. In order to attract and retain employees, employers strive to establish health care plans. The increased knowledge of health care and its importance to small employers is exemplified by the ranking of this issue as second among all recommendations voted upon by small business delegates to the 1986 White House Conference on Small Business.

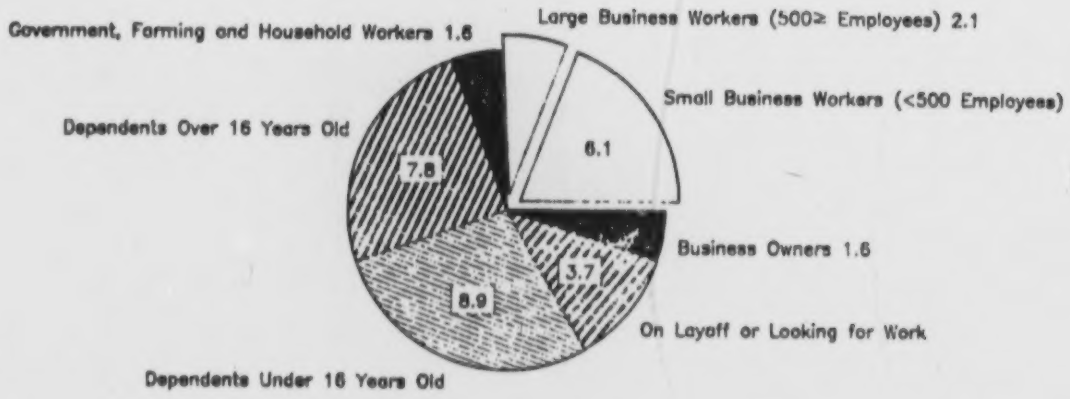
There are three trends that make health care an issue of highest concern to small firms. First, how can small employers provide affordable health benefits for themselves and their workers in an era of rising costs? Health expenditures in the United States have increased from $42 billion in 1965 to $425 billion in 1985. In that year health care expenditures comprised almost 11 percent of the Gross National Product, and growth in health care costs continued to outpace the rate of inflation. Medical prices increased by almost 8 percent in 1986, compared to a 1.1 percent general inflation rate. In 1986, health care costs averaged 8 percent of payroll, for an employer outlay of almost $1,500 per employee (The Wyatt Company, 1986). All employers--especially small employers who experience higher than average costs--are interested in keeping costs down, while providing quality health benefits.

Second, changing demographics will heighten the importance of affordable health plans to small business. An increasingly elderly population means that even greater efforts will be needed to check rising health costs. In addition, as growth of the labor supply slows and there are fewer workers available, health benefits will be an important tool in helping small employers compete for the most qualified labor.

Finally, and most important, there is much talk about the growth in the medically uninsured population in this country. Attention has focused on expanding employer health benefits to cover many of these people. Small businesses are at the center of this focus because most of the working uninsured are found in small firms. According to our 1984 figures from unpublished Census data there are about 32 million uninsured individuals (Chart 1). Approximately 8.2 million, or 26 percent, are

Chart

Population Without Health Insurance (Millions)



Total Uninsured = 31.8 Million

Source: U.S. SBA, Office of Advocacy, Census SIPP Data, 1984 private sector nonfarm workers who are employed all or part of the year. Of the working uninsured, 6 million are in firms with under 500 workers, with the majority employed in the smallest companies of fewer than 25 employees (Chart 2). In addition, another 1.6 million of the uninsured are business owners, primarily sole proprietors.

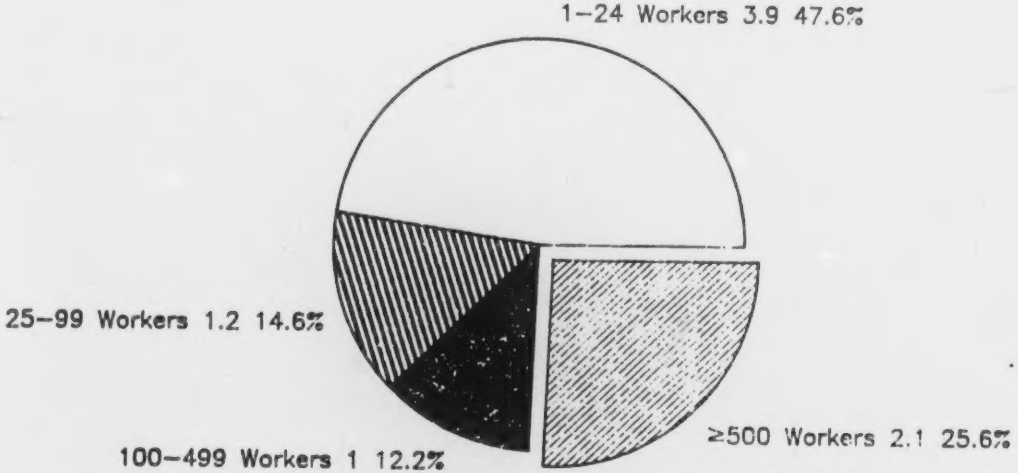
It is important to observe that even mandatory employer-sponsored health coverage will never cover all of the uninsured. Almost 4 million of the uninsured are laid off or looking for work. The largest category of uninsured consists of nonworkers (16.7 million), many of whom are children. It is unclear how many of these individuals have access to employer-provided health insurance, this is something we are working on, but many are nonworking single heads of households with children.

WHO SHOULD PAY?

Providing minimal health coverage to every medically uninsured person would cost upwards from $20 billion. The hard issue facing us is: if we want to cover all of these people who is to pay? The choices lie between employers, beneficiaries, or government. Employer-sponsored plans have burgeoned since World War II when they began to receive favorable tax treatment. While the employer and workers pay for health

Chart -

Workers Not Covered by Any Health Insurance by Firm Size, 1984
(Millions)



Employment Size of Firm

Source: U.S. SBA, Office of Advocacy, Census SIPP Data, 1984 costs, they are subsidized by Federal monies to the extent the employer deducts health benefits as business expenses and excludes health plan contributions from employee payroll and income taxes.

At the same time, employers and workers pay a considerable share of income and payroll taxes for government health programs. In addition, there has been a trend to shift beneficiary responsibility away from government and onto employers. In Fiscal Year 1987 alone, such additional costs to employer plans are estimated at $1.8 billion in benefit payments, plus an additional amount in administrative costs.[1] For example, employers with health plans are now the primary payer, rather than Medicare, of elderly workers' and elderly spouses' health care. Under the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA), employers are also required to continue to offer health insurance to employees who leave, widows, divorced spouses, and certain dependents. (If they elect such coverage, beneficiaries pay 102 percent of the premium cost.)

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[1] "Mandated Coverage: An Employer Debate," Brian Rasmussen, Business and Health, Washington, D.C., 1987, p. 12.

Among health policy experts many propose building upon the tradition of employer-sponsored health insurance to cover part of the uninsured population. Since this still excludes a large portion of the uninsured, other mechanisms will be needed to ensure coverage of those who cannot afford or do not have access to any employer protection.

The debate for employer plan expansion has centered on two approaches: mandating such coverage or creating voluntary incentives to encourage expansion. There is a strong consensus within the small business community to oppose any type of mandate, for reasons detailed below. After careful examination of the nature of the kinds of firms that lack coverage and the characteristics of medically uninsured workers, I suggest that we rethink the type of coverage that is expected of and available to employers and employees. Unlike any mandate proposal, developing and broadly marketing a catastrophic health insurance plan could significantly lower costs to the point where small employers without health plans would voluntarily purchase such insurance. The tremendous detrimental effects of a mandate would not ensue. Before elaborating on this and other voluntary options I would like to talk about our research findings which are the basis for my conclusions. I will also outline some of the difficulties associated with the mandated benefit approach.

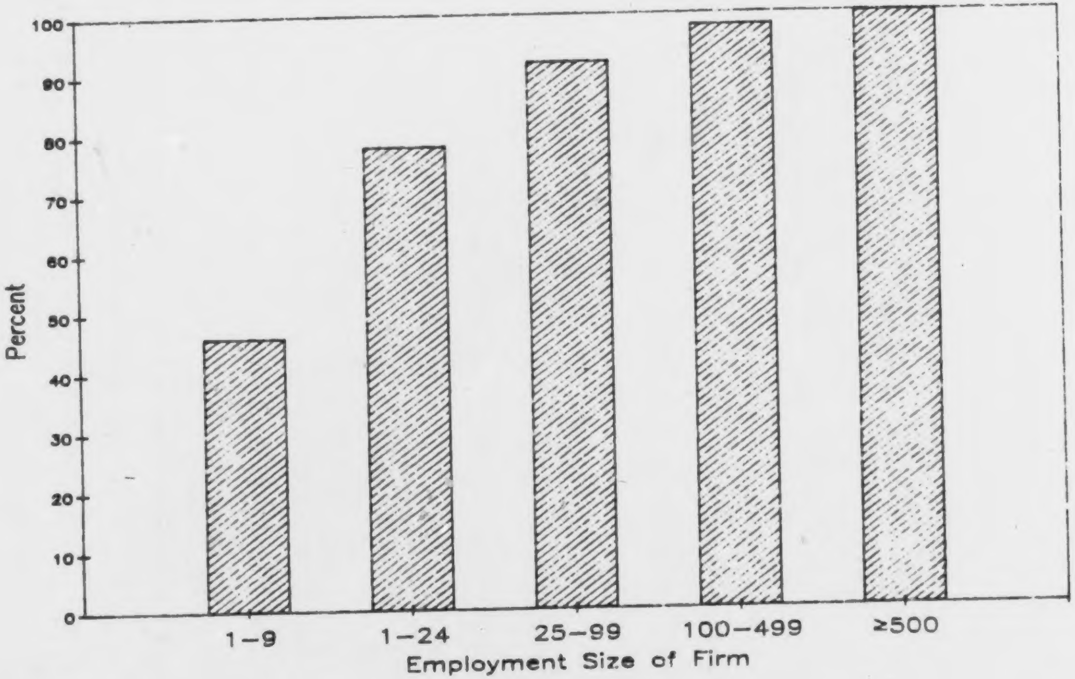
REASONS FOR LACK OF COVERAGE IN SMALL FIRMS

Let me preface my remarks by noting that most of the facts and figures are from a 1986 employer survey conducted by the Office of Advocacy. Much of the information is confirmed by other unpublished household-based data we have analyzed from the Department of Commerce's Bureau of the Census' Survey of Income and Program Participation (SIPP). I am releasing a summary of the employer survey today. Full copies are also available to the Committee.

Not surprisingly, as is true for all fringe benefits, the prevalence of health care increases with firm size (Chart 3). The greatest gaps are between firms with under 10 or under 25 employees and those employing more than 25 workers. As mentioned, 48 percent of all uninsured workers are in firms with 1-24 employees. (If the ten percent of business owners without coverage were added in, the figure approaches 60 percent.) I cannot emphasize enough the importance of the relationship between size and the likelihood that a firm will offer coverage. In firms with over 24 employees, over 90 percent of employers within each size category offer health benefits to workers.

Chart 3

Percentage of Firms that Offer Health Benefits



Source: U.S. SBA, Office of Advocacy, ICF Report, 1986

There is a sort of Catch-22 for the smallest companies. They are more likely to have insignificant, unstable, or non-existent profits, yet they are charged more for group health insurance. This situation is not the result of any market imperfection, rather it simply costs more to underwrite and administer a small firm plan. Premiums are priced higher because there is a smaller number of people among whom to spread risk: one high cost illness has a much greater affect on a small than large firm. It is also much more costly for an insurance company to cover 10 employees in 100 firms than 1000 employees in one large firm. More rapid worker turnover in small business and the greater chance that small employers will change carriers are other contributing factors that drive up health insurance rates for these firms.

Data indicate that premiums in small companies run 10-15 percent higher than large firms. In non-self-insured plans small firm (under 100 employees) average monthly premiums are $85 for single coverage and $205 for family coverage, compared with $77 and $181, respectively, for firms employing more than 100 workers. I expect these costs are likely to be low, as a recent article in the Washington Post indicated that this year many insurers are raising small employer premium rates by as much as 70 percent.[2]

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[2] "Health Insurance Companies Raising Premiums Sharply," Michael Abramowitz, Washington Post, April 20, 1987, p.1.

If benefit and in-house administrative differences are taken into account and if the costs of large business' self-insured plans are used as a point of comparison, the gap widens further. Small employers simply get less benefit for the dollar.[3] Because they cannot afford trained benefits personnel to assist enrollees, follow health regulations, or implement cost containment measures, small business administrative costs are disproportionately higher and utilization is not as efficient. Moreover, because of the small size of the insured group and inability to spread risk, few of these firms can self-insure, an alternative to which large companies have turned as a way of lowering costs. Only five percent of firms with under 100 workers are self-insured, while at least 40 percent of firms with over 500 employees use this method. Around two-thirds of small firms have traditional indemnity insurance plans, which gives them less flexibility to control costs.

Health plans may also be relatively more expensive for very small employers because small employers are more likely to pay all health premium costs rather than require some employee contribution. Seventy percent of firms with fewer than 100 workers pay all of their employees' single premium contracts, compared to 61 percent of firms with 100 or more workers. Small employers may pay the full premium because it is less of an administrative headache to do so, or because they are making up for fewer fringe benefits overall.

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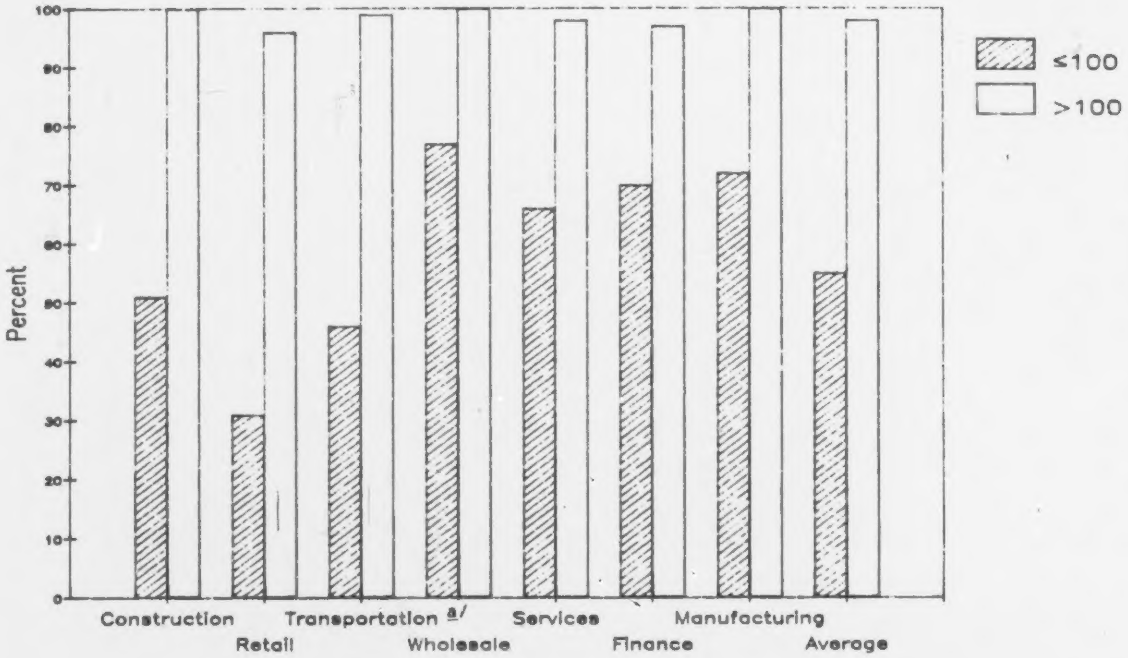
[3] Very small firms with 10 or fewer employees tend to have more generous benefits than businesses of 11-24 workers. This may be because many of these companies employ family members and, therefore, prefer broader coverage. Alternatively, these companies frequently are required to buy a set package that cannot be altered.

Other factors affecting the provision of health benefit coverage are industry and the legal form of business. The bulk of companies without coverage lie in the retail trade and construction industries (Chart 4). Forty percent of all firms which do not sponsor health plans are retail trade firms with less than 10 employees. Data also indicate that workers in certain services are also significantly more likely to be without coverage. These industries are characterized by lower and variable profits, high turnover, and an inordinate number of part-time, seasonal, or young workers.

As far as legal form, overall 29 percent of sole proprietorships offer coverage, compared to 49 percent of Subchapter S corporations, and 77 percent of corporations (Chart 5). Even in the smallest size category of 1-9 employees, corporations are more than twice as likely to provide coverage than a sole proprietorship or a Subchapter S corporation. I think that this says a lot about the differences in tax incentives for deducting health insurance among different business owners and I will come back to this point later.

Char. 4

Percentage of Firms that offer Health Plans, by Industry and Firm Size

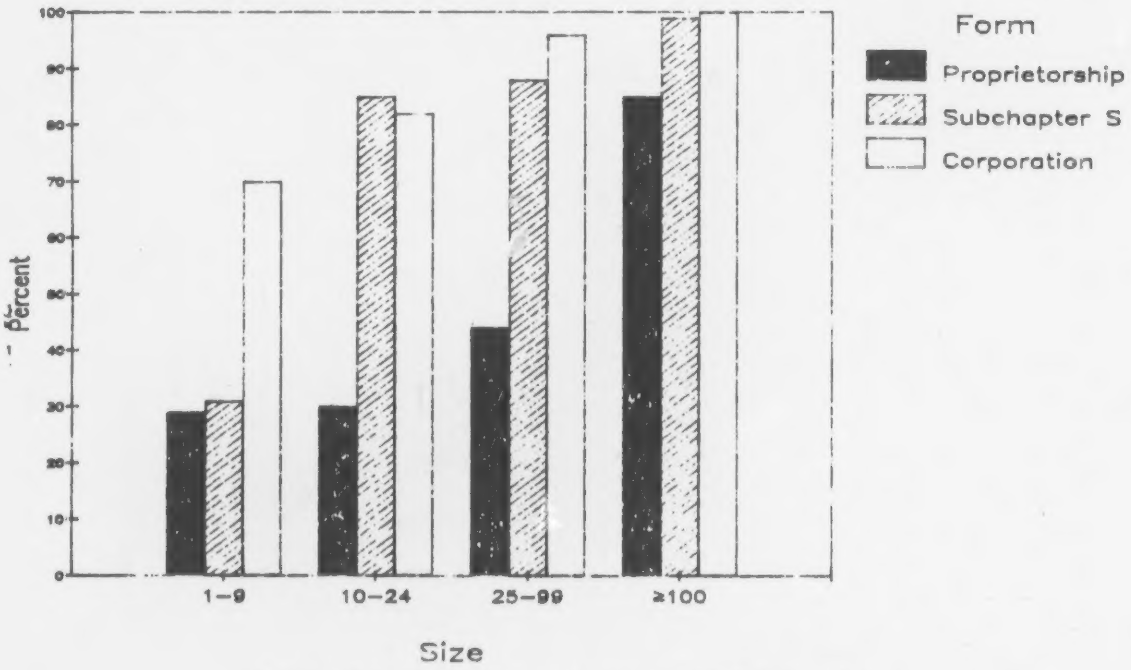


Source: U.S. SBA, Office of Advocacy, ICF Report, 1986

a/ Includes agriculture and mining.

Chart

Percentage of Firms that Sponsor Health Plans
by Employment Size and Form of Ownership



Source: U.S. SBA, Office of Advocacy, ICF Report, 1986

Worker characteristics also affect whether a firm offers coverage. First, certain workers are proportionately more expensive to insure, e.g., part-timers. Second, some workers do not want or cannot afford to purchase health benefits, so an employer's risk pool is reduced even more, leading to more expensive health care for remaining employees. The prevalence of certain kinds of workers in small firms often leads a small employer to decide not to establish a health plan. Workers most likely to be medically uninsured, as well as employed in a small business are part-timers, young workers, and low-wage workers (1984 Census SIPP).

Part-timers are particularly noteworthy because this group, along with temporary/seasonal workers, are the most likely to be excluded from eligibility in any health plan. Overall, 68 percent of all companies exclude part-time workers and 50 percent exclude temporary or seasonal workers. These workers are relatively expensive to insure since health insurance costs the same as it does for a full-time employee. But contrary to what one would hypothesize, small employers are more likely to make these workers eligible than large employers. The reason may be that small firms want to attract and retain these workers, or include them to broaden their health risk pool. Whatever the reason, frequently these workers do not elect coverage from their employer. Around 14 percent of eligible workers in small firms turn down coverage in their firms' plans, compared to 7 percent in the largest companies. Many of these workers are secondary wage earners in their household and it is more efficient for them to purchase health care through a spouse's plan. (I might add that the spouse may be employed in a small or large firm.) Others may turn down health benefits because it is prohibitively costly for them.

Younger workers, who are in general very healthy, frequently prefer higher wages instead of employee benefits. If young workers remove themselves from a small employer's pool, the average cost per employee could be considerably higher. Small companies also hire approximately 80 percent of all older workers who, on a per capita basis spend almost three times as much as the general population on health care.

Many of the smallest companies consist of low-wage workers. It may not be feasible for them to pay for any health expenses, or if there is a tradeoff, higher wages would be preferable.

Keeping in mind these sound economic reasons for why 100 percent of all employers do not sponsor health plans or make 100 percent of their workers eligible for benefits, I would now like to turn to employer-mandated health care.

THE EFFECTS OF A MANDATE

Several members of Congress have decided that the best way to expand employer-sponsored health care is to force employers to do so by law, including specified employer contribution levels. First, although it is traditional that workers obtain health coverage through their employer, it is also traditional that employers maintain a voluntary flexible benefits system. This flexibility, or lack thereof, may determine (a) whether an employer even goes into business, (b) the number of workers that can be hired, and (c) the kinds of benefits an employer may offer and the degree to which they can be tailored to meet the needs of a work force.

I've already discussed the fact that small firms pay more for less. Mandatory coverage will not lower costs - indeed it is more like handing the insurance industry a captive market on a silver platter. This approach mirrors what has occurred at the state level where over 640 mandates ensure a market for a plethora of health care providers and keep health costs (and thus insurance costs) escalating. The mandate proposals for employer-sponsored health plans that I've seen include no cost information at all. Instead, they only specify a considerable number of benefits required to be offered. This is disingenuous at best: it will cost small employers very real dollars to provide coverage-particularly if Congress dictates the minimum benefit as well. Because health costs vary significantly across the country, some areas will be especially hard hit by a mandate. Small companies, which typically have low profit margins, and likely to be at a disadvantage in shouldering these costs.

Our study revealed that the number one reason employers cited as to why they did not offer insurance was insufficient profits. A mandate does nothing to help out these firms. In addition, other entrepreneurs contemplating going into business may be discouraged from doing so as the costs for starting up are raised. Many policies are promoted because they will increase the dramatic job generation contribution of small firms. Mandated health care coverage is a policy to do just the opposite - it will make it more expensive to have any or more employees.

Small business can be expected to pay for a mandate by shifting costs to consumers by raising prices, where possible, or to workers by reducing wages. Lower and minimum-wage employees' compensation cannot be reduced to absorb the added costs of a mandate, with the result being increased layoffs or reduced hiring. Another unintended employment consequence would be an increase in hiring of persons who would be exempt from the mandate, such as independent contractors or part-time employees. A mandate approach will not resolve the problem of the uninsured and, in fact, is likely to only increase the current pool of 3.7 million unemployed uninsured.

I think we need to be upfront about the consequences of a mandate and label it as renowned professor of political economy Uwe E. Reinhardt does: a tax on employment and entrepreneurship.[4] I have heard some health experts question small business' contribution to job growth. Maybe a few facts can clear up this misperception. Between 1976 and 1984, small firms in the United States with fewer than 500 employees generated 60.5 percent of America's 17 million new jobs. More recently, between 1982 and 1984, small firms created 76.2 percent of jobs in the United States.

Small business job growth in the three industries most likely to be affected by a health mandate are also dramatic. Between 1982 and 1984 in construction, 100 percent of all job growth came from small businesses, in services the contribution was 55 percent, and in retail trade almost half of all new jobs were in small firms.

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[4] "Should All Employers Be Required By Law to Provide Basic Health Insurance Coverage for their Employees and Dependents?," Uwe E Reinhardt, Ph.D., advance paper for the Employee Benefit Research Institute policy forum on "Government Mandating of Health Pension, and Other Employee Benefits." April 27, 1987.

A tax on employment and entrepreneurship is also contrary to our policy of increasing employers' competitiveness abroad. Some health experts favoring a mandate assert that small firms likely to be affected do not compete internationally and, therefore, won't be hurt in this manner. What is not stated is that many of these small firms are suppliers to large companies that do compete internationally. Higher costs for a supplier surely affects costs for the purchasing firms. It is an important goal of our current export policy to increase opportunities abroad for smaller companies exporting both products and services. Let's not curtail growth in this promising area by creating a new tax.

VOLUNTARY POLICY OPTIONS

A mandate will not resolve the uninsured problem and is likely to have disastrous side effects. The focus should be on voluntary incentives that are likely to increase employer coverage and a variety of competing insurance products that assure lowest cost health care for the greatest number of Americans. There are several such initiatives already underway at the state level and opportunities for new initiatives that may be undertaken.

States are presently experimenting with ways to extend private health insurance to low-income, uninsured workers employed in small firms and developing affordable health insurance products. Efforts range from organizing small firm Multiple Employer Trusts to exploring the feasibility of creating a health insurance information and referral service for small businesses.

There are several new initiatives Congress could consider. One is to promote private catastrophic insurance for the general population, which is currently unavailable. By establishing low premiums with high deductibles and specified care benefits, it may be possible to lower costs to the point where small employers will voluntarily purchase such plans.

Initiatives designed to increase the coverage of those workers currently uninsured may also need to include provisions for assisting low income workers with the high deductible (for example $2,000) in a catastrophic coverage plan. Finally, I urge expansion of the tax deduction for unincorporated business owners from the current 25 percent to the 100 percent deduction that is available to corporate owners.

Both the Department of Health and Human Services (DHHS) and Treasury are analyzing some of these proposals. Specific areas under examination by DHHS include changing Federal requirements to allow states greater flexibility in managing Medicaid programs and including catastrophic protection in employment-related insurance. Studies being conducted by the Department of Treasury include expanding the 25 percent tax deduction for sole proprietors or unincorporated businesses to 100 percent if catastrophic coverage is included in their health insurance plans.

It will take some effort to work out the policy details needed to extend a catastrophic health plan to a large segment of uninsured Americans. However, the basic features must include low premiums, high deductibles, and coverage of specified core benefits. The direction should be to move away from first dollar coverage that includes every type of benefit and covers every provider and toward a more scaled down and affordable health plan. Rather than focusing on a mandate, policymakers should start looking at coverage that could significantly reduce the price of group health insurance. A mandate would be unnecessary if an affordable catastrophic plan were developed and marketed to employers because they would voluntarily purchase such a plan. However, the feasibility of providing a reasonable low cost health plan may well depend upon eliminating the plethora of state mandates currently required to be included in any group health insurance. These mandates discourage the development of alternative benefit packages.

The main drawback to emphasizing catastrophic care as the way to provide health care benefits through more employers is that the cost of the high deductible for persons who are low income, but not poor enough to qualify for government Medicaid assistance, may preclude them from being able to share the cost of such coverage. Although the trend has been toward paring back state Medicaid programs, there are some important pilot programs in place that could shed light on the practicalities and economics of covering the low-income uninsured. State governments should be encouraged to explore ways that the uninsured working poor and others not currently eligible can tie into this program.

Finally, I note that the Tax Reform Act of 1986 introduced an important incentive to increase employer health coverage by allowing a 25 percent tax deduction for unincorporated business owners. While the benefits to operate as a sole proprietor or partnership versus a corporation, however, have been equalized in most areas, they have not been in the area of health insurance deductions. I look forward to the Department of Treasury's analysis on expanding the tax deduction for unincorporated owners from 25 to to 100 percent. This incentive can increase coverage in unincorporated firms which are only half as likely as corporations to offer coverage. Health benefits can then be expanded to these owners, their families, and their workers.

CONCLUSION

In sum, the small business community is interested in positively contributing to resolving our nation's health care problems. We believe the facts on health care and small business speak for themselves. I recommend that we start small by encouraging a general catastrophic insurance product. Employer-sponsored health benefits can best be expanded by lowering the costs of care. This, combined with pilot programs for low-income workers, and an extension of the health tax deduction for unincorporated business owners, should go a long way toward achieving our goals.

Mr. Chairman, providing health benefits to 32 million uninsured Americans is a significant challenge. Employers can help in meeting that challenge ...at least so far as the uninsured are in the work force. Changes are needed in regulation of employer provision of health care. I believe these changes should increase incentives for flexible, competitive benefits. In contrast, mandated coverage and benefits will impose considerable costs - directly on small firms and indirectly on rates of business formation and employment growth.

We should not presume that resolution of all of our concerns for the uninsured can be resolved by employers. Government, beneficiaries of government or private health coverage and employers can all play a role. I welcome your attention to the small employer side of the issue and will be pleased to respond to the Committee's questions. Thank you.

Senator BUMPERS. I just have one question, do you have any kind of a study that indicates how many people—how many small businesses, say less than 100 employees, provide coverage based on the age of the firm? In short, are those firms that are older more likely to have coverage than the newer firms, or vice versa?

Mr. SWAIN. Yes, we did take a look at that, Mr. Chairman. Surprisingly—to me at least—those firms that did not have coverage tended to be fairly typical across-the-board mixture of old and new firms.

Senator BUMPERS. So the age of the firm does not seem to be a factor?

Mr. SWAIN. A much more important factor is the kind of business and the size of the firm. If it is a small firm, that seems to make the biggest difference.

Senator BUMPERS. One other question. Your chart showed something I do not understand. Your very first chart shows the size of the firms and how many workers are covered and the percentage of workers in that particular category. You show that you have 100 to 500 workers, there are 1 million workers in that category not covered, or 12.2 percent of the total work force in firms of 100 to 500 employees are uncovered.

Mr. SWAIN. Yes, sir.

Senator BUMPERS. Then the very next one you show that in firms of more than 500 employees, 25.6 percent are uncovered.

Mr. SWAIN. Yes, sir. Of the 8 million people who are working and who do not have insurance, 25 percent or 2 million of those 8 million work for businesses with more than 500 employees. Approximately 6 million of those 8 million work for small businesses.

Senator BUMPERS. So you are saying that of the 8 million working individuals who have no insurance, 2.1 million of them that are uncovered work in firms of over 500 employees?

Mr. SWAIN. Yes, sir. And our statistics are based on Bureau of the Census surveys.

Senator BUMPERS. That is a very strange figure to me.

Mr. SWAIN. Let me suggest a couple of explanations. The large firms that do not provide this coverage are probably large firms who have a large number of part-time or temporary workers and whose coverage may not extend to part-time or temporary workers.

Senator BUMPERS. If I knew the total workforce that we were looking at—in other words, if I knew the total workforce in each one of those categories, that figure might make a little more sense.

Mr. SWAIN. Well Mr. Chairman, if—just off the top of my head—there are roughly 85 million private sector non-agricultural Americans working—probably more but I will use it as a base figure. Roughly speaking, half of those people work for large business and half work for small business. So we are talking about 2 million out of 42 million workers in large businesses who are not covered, but we are talking about 6 million out of 42 million small business workers who are not covered.

Senator BUMPERS. Senator Dixon.

Senator DIXON. I just want to say, Mr. Chairman, that I find Mr. Swain's testimony very, very interesting and helpful and informative.

If I could just go over a little bit of it with you again so I fully understand it. I believe your testimony is that there are 32 million people out there that have no insurance.

Mr. SWAIN. That is correct.

Senator DIXON. But only 8 million of them are actually employed, so that even if the Congress wanted to undertake a mandatory insurance program, which I consider highly unlikely, it would only affect 25 percent of those uninsured folks out there.

Mr. SWAIN. That is right.

Senator DIXON. That is my understanding of your testimony.

Mr. SWAIN. That is right.

Senator DIXON. Now if I look at chart 13—page 14, the chart on that page; that really interests me. If I understand what you are saying there, you are telling us that in small corporations of under—nine or less employees—I am an old lawyer—years ago I used to be a general practitioner in a small town of 40,000 people and some people would incorporate their little businesses for a variety of reasons. But you are saying that those little Mom and Pop concerns that actually do incorporate do in fact provide insurance coverage in 70 percent of the cases. Is that true?

Mr. SWAIN. Yes, sir.

Senator DIXON. Even these small operations. Am I correct?

Mr. SWAIN. Yes, sir.

Senator DIXON. Now what about Subchapter S's, do they not have the advantage of full deductibility from a tax standpoint of the major owner, and so forth?

Mr. SWAIN. Well, tax practitioners are welcome to correct me, but my understanding is that a Subchapter S corporation is as a legal entity a corporation. As a corporation it has shareholders and, therefore, it would be able to deduct the full cost of its health insurance premiums as an appropriate employee benefit.

Senator DIXON. Well then I do not understand, because if you look at this, the Subchapter S is not the very favorable situation with respect to sole proprietorship. You know it is a difference of a couple of percentiles. So I do not get the point there.

Mr. SWAIN. Well, I have no explanation for why the Sub S figures are so low for the smaller firms.

Senator DIXON. I was very anxious to pounce upon that to support the Chairman's observation that making 100 percent deductibility would be very persuasive in bringing a great number of this 8 million people under—coverage apparently 50 percent of them would come under it.

Mr. SWAIN. I only have one thought at this juncture, Mr. Chairman, and we will try to take a closer look at it later. For the very smallest companies, the number of those Sub S companies may in fact represent tax loss shelters.

Senator DIXON. I see some nodding yes.

Mr. SWAIN. It is a terrible word, we hate to mention it, but a Sub S has in the past been the typical way of organizing a tax shelter.

tax laws in that area quite frankly, but I find it very interesting because if my first impression was a correct one, that simply giving the owner the tax advantage of the full deduction brings in the whole herd, then that entices me greatly and I would be interested in seeing the revenue consequences. So that is a thing I would be interested in, and may I request that you, Mr. Swain and the Committee pursue that further.

The other observation I had was implicit in some of your testimony and that was that maybe in a private sector way we could make new inducements, you called them bare bones type things. That caused me to want to recollect some of my old experiences as a member of the Illinois House of Representatives—I hate to tell you how long ago. In those days we did not have any kind of mandatory casualty insurance in my State but if you were in an automobile accident you lost your driver's license so it was very important to have some kind of insurance. Since we could not pass mandatory insurance, nobody wanted it, what the legislature invented was what we called an assigned risk pool. It was essentially, Mr. Chairman, a bare bones insurance policy, I believe in those days only $10,000 to $20,000 coverage. I am talking about the very early 1950's. But of course you could go buy that bare bones insurance very, very cheaply under that assigned risk pool that everybody had to belong to do business in our State, and consequently had the privilege of driving an automobile, so it had great attractiveness and we found very few uninsured motorists as a consequence.

The only reason I throw that into the formula here is that to avoid the kind of comprehensive mandatory coverage that I think nobody here wants, certainly not this Senator, Mr. Chairman, we might look at that possibility from a tax deduction standpoint, to implement what we see in the chart on page 14. If I interpret that correctly, you can extrapolate from it that you would get all this additional coverage, and would reduce the 25 percent who are now not insured by their employers by 50 percent by doing that.

And then if you had some kind of a bare bones assigned risk pool type of opportunity out there for others, you might very well pick up most of the slack that the Congress can do anything about on a voluntary basis. I think that would be exceedingly attractive to the business community.

And so I would just ask you, Mr. Swain, in your position as an advocate of the small business interests in this country, to give that some thought and at least this Senator and perhaps others, would be very interested in having your response in due course.

Mr. Swain. We will, Senator, and you may be able to inquire about this of one of your later witnesses, Travelers Insurance. Travelers has experience with a type of risk pool arrangement in the State of Connecticut. There are some 9 or 10 other States that have various forms of health policy risk pools. It certainly, I think, is an important avenue of inquiry as an option.

I think the key is whether one requires employers to pay into that or whether it is, as you suggested analogous to your Illinois situation, that people have the option where they cannot obtain insurance otherwise to subscribe to that sort of arrangement.

Senator Dixon. Exactly. I thank the Chair.

Senator Bumpers. We are working on a bill that will increase the deduction which the self-employed receive for their health insurance costs. The self-employed should be put on equal footing in this area.

Senator DIXON. I am interested in that, Mr. Chairman, and at the expense of exciting a lot of people in small corporations in the country, I might observe on the basis of what little I know about that as an old general practitioner, that there is very little decent legal argument for the treatment of one group distinguished from another group.

Senator BUMPERS. I cannot think of any. Senator Harkin.

Senator HARKIN. Mr. Chairman, I have no questions.

Senator BUMPERS. Thank you very much. Mr. Swain, thank you very much.

Our next two witnesses form a panel; Mr. Powell Jenkins and Mr. Fredric Rohm. Mr. Jenkins is the owner of Jenkins Hardware, Inc., Rocky Mount, NC. Mr. Rohm is president of the New Castle County Chamber of Commerce in Newark, DE, and speaks for the national Chamber.

Mr. Jenkins, would you proceed please?

STATEMENT OF POWELL JENKINS, JENKINS HARDWARE, INC., ROCKY MOUNT, NC

Mr. JENKINS. Thank you, sir.

Mr. Chairman, my name is Powell Jenkins and I am from Rocky Mount, North Carolina. I own and operate a small retail hardware store. I opened my store 8 years ago and since that opening, I have faced what seems to be a continual onslaught of problems. Some of the problems have been of my own making. I have had to learn the retail business from the ground up. I have faced, and am continuing to face, the problems that all new entrepreneurs face: Lack of capital, inadequate cash-flow, staffing problems, meeting a payroll each week, and making my business an asset to the community. The financial crisis and high interest rates of the early 1980's presented an almost insurmountable burden for my small business. Yet, I managed to survive. The assaults on my business have caused me to become more adaptive, more flexible; in short, a better businessperson.

In today's economy, one must learn to capitalize on his assets and eliminate, or at least greatly reduce, his liabilities. If I am to succeed in my hardware store, I must either increase sales or reduce expenses. I already have expenses that I cannot control; rent, utilities, FICA taxes, minimum wage. Now I find there is a movement in Congress to give me another uncontrollable expense—mandated health benefits for my employees.

Mr. Chairman and members of the committee, allow me to use the experience I have in a small retail business to tell you why I feel that mandated health benefits for employees will greatly hinder the success of my small business and other small businesses. As a member of the National Federation of Independent Businesses, I would also like to submit their additional statement for the record.

Mandated health coverage will slow the rate of employment for small businesses. When I made the decision last year to hire a new employee, I had to determine what that new employee would cost me in relation to what benefits I would receive. As you know an employee costs more than his salary. In a small retail business it is necessary to closely monitor expenses. Even at minimum wage, it costs almost $500 a month to employ someone. Health insurance is very expensive.

If I am to cover the employee's hospitalization, I have just added 10 percent to the cost of that minimum wage employee. The net effect on me, the small business owner, is to hire someone only when it is absolutely necessary.

Historically, the small business sector has provided the largest number of new jobs annually. Think of the ripple effect that this artificial constraint would have on the nation's employment rate. Instead of adding two new jobs this year, I might only add one or even none at all. Also, in order to fill a position I may have, I may limit myself to hiring someone who has a spouse that works for another employer that provides hospitalization. Or, I may hire only a single person so I will not have to provide dependent coverage. Am I now opening myself up to a new kind of discrimination suit? All these questions will go through my mind as I prepare to fill that position.

Mandated health benefits will be very costly, and oftentimes are difficult to obtain. I employ three people. One is covered under a spouse's plan. I must buy coverage for two people. Not every insurance company offers coverage for a two-person group. Last year, coverage for those two persons cost me $500 a month. I have just received my annual premium renewal notice. My monthly premium will be increased to $650 a month. Over 7 percent of my gross profit goes to provide hospitalization for my employees, which I pay 100 percent of the cost.

Mandated health benefits may not be universally available. Of the three employees I have, two have extensive medical histories. One had a heart attack 3 years ago, before I employed him. Coverage might not be available for him if he were not covered under a spouse's plan with a major corporation. Another employee's wife has high blood pressure. Two companies I contacted sought to limit coverage on her. Finally coverage was secured without limitation, but not without its high price.

Mandated health benefits will be expensive to administer, particularly for the small business with a high employee turnover. Many of the businesses I sell to experience a continual turnover of employees. Unfortunately this seems to be the rule rather than the exception in many contractor and construction trades. The burden will be on the small business owner and the insurance company to handle the administrative nightmare that will result when employees come and go. Invariably the price will go up.

Mandated health benefits could head to inequities between comparable employees. If I must discharge an employee due to a general business downturn, will the presence of a mandated hospital benefit affect my decision on who I should discharge? Should I discharge that employee that costs me $600 a month in salary or should I discharge that employee that costs me $600 a month in salary and $200 a month in hospital benefits?

An employer in the past has offered to pay the cost of hospital insurance as a method of keeping that desired employee. Indeed, the percentage of small business owners offering health coverage seems to be rising. Perhaps this rise reflects the importance that small business owners place on hiring and keeping good employees.

A large percentage of the member firms of the National Federation of Independent Businesses pay the entire cost of the hospital insurance that they provide their employees.

The six reasons I have given above reflect some practical concerns that I have with mandated health benefits. I have some serious philosophical problems with the mandating of benefits. Our Nation's economy is based on the free enterprise system. One tenet of that free enterprise system says to let the marketplace decide the value of a product or service. Small business owners are recognizing that in order to compete in the marketplace for good, reliable employees, the small business may need to provide health coverage. The small business owner should be able to provide this coverage based on his ability to pay, his desire to keep valued employees and his ability to find available coverage. To interfere in the marketplace by mandating health coverage could have a potentially devastating effect on a large number of small businesses. The mandate could lead to administrative nightmares, strained profitability, lack of growth in employment and perhaps ultimately in a decline in the number of new small business starts.

The affordability and availability of health care in America is a national crisis. Placing an unreasonable burden on the small business owner by requiring that he provide hospitalization is not the answer to the problem. That course would lead to the ruination of many small businesses.

I appreciate the opportunity and the honor of speaking to you today. I further appreciate the concern you show for the small business sector by allowing someone like myself to speak with you.

I will gladly attempt to respond to any questions I can.

Thank you.

Senator BUMPERS. Thank you, Mr. Jenkins.

[The prepared statement of Mr. Jenkins follows:]

STATEMENT OF
POWELL JENKINS
before
SENATE SMALL BUSINESS COMMITTEE
April 23, 1987

Mr. Chairman, my name is Powell Jenkins and I am from Rocky Mount, North Carolina. I own and operate a small retail hardware store. I opened my store eight years ago and since that opening, I have survived what seems to be a continual onslaught of problems. Some of the problems have been of my own creation. I have had to learn the retail business from the ground up. I have faced, and am continuing to face, the problems that all new entrepreneurs must overcome -- lack of capital, inadequate cash flow, staffing problems, meeting a payroll each week, and making my business an asset to the community. The financial crisis and high interest rates of the early 1980's presented an almost insurmountable burden for my fledgling business. Yet, I managed to survive. Survive and grow. The assaults on my business have caused me to become more adaptive, more flexible -- in short, a better businessperson.

A businessperson in today's economy must learn to capitalize on his assets and eliminate, or at least reduce, his liabilities. If I am to succeed in my hardware store, I must either increase sales or reduce expenses. I already have expenses that I cannot control -- rent, utilities, FICA taxes, minimum wage. Now I find that there is a movement in the Congress to give me another uncontrollable expense -- mandated hospital insurance for my employees.

Mr. Chairman and members of the committee, please allow me to use the experience I have in my small retail business to tell you why I feel that mandated health benefits for employees will greatly hinder the success of my business. As a member of the National Federation of Independent Business, I would also like to submit their additional statement for the record.

1. Mandated health coverage will slow the rate of employment by small businesses. When I made the decision last year to hire a new employee, I had to determine what that new employee would cost in relation to what benefits I would receive. An employee costs more than his salary. In a small retail

business, it is necessary to closely monitor expenses. Even at minimum wage, it costs almost five hundred dollars a month to employ someone (based on a forty-hour week). Health insurance is very expensive. If I am to cover the employee's hospitalization, I have just added at least ten percent to the cost of that minimum wage employee. The net effect on me, the small business owner, is to hire someone only when it becomes absolutely necessary. Historically, the small business sector of the economy has provided the largest number of new jobs annually. Think of the ripple effect that this artificial constraint could have on the nation's employment rate. Instead of adding two new jobs this year, I may only be able to add one -- or, maybe even none. Also, in order to fill a position I have, I may limit myself to hiring someone who has a spouse that works for another employer that provides hospitalization. Or, I may only hire a single person so as not to incur the expense of dependent coverage. Am I now opening myself up to a whole new kind of discrimination suit? All these kinds of questions will go through my mind as I prepare to fill a position. Is the economy strong enough to handle any kind of suppression of the rate of employment?

2. Mandated health benefits will be very costly, and are difficult to obtain for very small companies. I employ three

people. One is covered by a spouse's plan. I must buy coverage for two people. Not every insurance company offers coverage for a two person group. Last year, coverage for those two people cost me over five hundred dollars a month. I have just received my annual renewal notice. My monthly premium will be increased to over six hundred fifty dollars a month. Over seven percent of my gross profit goes to provide hospitalization for my employees.

3. Mandated health benefits may not be universally available. Of the three employees I have, two have extensive medical histories. One had a heart attack three years ago -- before I employed him. Coverage might not be available for him if he were not covered under his wife's plan with a major corporation. Another employee's wife has high blood pressure. Two companies sought to limit coverage on her. Finally coverage was secured without limitation, but not without its high price.

4. Mandated health benefits will be expensive to administer, particularly for businesses with high employee turnover. Many of the businesses I sell to experience a continual turnover of employees. Unfortunately, this appears to be the rule rather than the exception in many contractor and construction trades.

The burden will be on the small business owner and the insurance company to handle the administrative nightmare that will result when employees come and go. The price of the product will go up also.

5. Mandated health benefits could lead to inequities between comparable employees. If I must discharge an employee due to a general business downturn, will the presence of a mandated hospital benefit on one and not on the other affect my decision on whom to discharge? Should I discharge an employee that costs me $600 a month in salary or one that costs me $600 a month in salary and $200 a month in hospital benefits?

6. An employer has in the past offered to pay the cost of hospital insurance as a method of keeping a desired employee. Indeed, the percentage of small business owners offering health care coverage is rising. Perhaps this rise reflects the importance that small business owners place on hiring and keeping good employees.

These six reasons represent practical concerns that will face the nation's small business owners should there be mandated health benefits for all employees. I have a very serious philosophical problem with the mandating of health benefits. Our nation's economy is based on the free enterprise system. One tenet of the free enterprise sytem is letting the marketplace decide the value of an idea or item. Small business owners are recognizing that in order to compete in the marketplace for good, reliable employees, the small business may need to provide hospital/health coverage. The small business owner should be able to provide those coverages based on his ability to pay, his desire to keep valued employees, and his ability to find available coverage. To interfere in the marketplace by mandating health coverage could have a potentially devastating effect on a large number of small businesses in America. This mandate would lead to administrative nightmares, strained profitability, lack of growth in employment, and perhaps ultimately, in a decline in the number of new small business starts.

The affordability and availability of health care in America is a national crisis. Placing an unreasonable burden on the small business owner by requiring that he provide hospitalization is not the answer to the problem. That course would lead to the ruination of many small businesses.

I appreciate the opportunity and honor of speaking before you today. I further appreciate the concern you show for the small business sector of the economy by seeking the input of a small business person like myself. I will gladly attempt to respond to any questions you might have.

Thank you.

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Senator BUMPERS. Mr. Rohm, you may proceed.

STATEMENT OF FREDRIC M. ROHM, PRESIDENT, NEW CASTLE COUNTY CHAMBER OF COMMERCE, NEWARK, DE

Mr. ROHM. Thank you, Senator Bumpers. My name is Fred Rohm and I am president of the New Castle County Chamber of Commerce from the State of Delaware. I am also a small business owner and member of the U.S. Chamber's Health Care Council. I will be speaking today not only on behalf of the U.S. Chamber but giving you some remarks that are pertinent to my own situation in the State of Delaware.

I appreciate the opportunity to testify. I would like to summarize my remarks, taking my cue from what you said earlier, but submit my full testimony for the record.

It is kind of a good news and bad news situation. The bad news is that, if we believe the numbers, there are 35 million uninsured. But the good news is that business is already providing the vast majority of the private sector with coverage, approximately 132 million people or 84 percent of the private health care coverage in the country. And this cost to business is about $105 billion in 1985.

I believe, however, that business can do more and can provide more and do it better if given the proper incentives. And that is what I would like to outline for you today.

First of all, I would like to note that there is quite a patchwork of State mandated benefits that face the small business people, not only members of my organization but that I face as a small business owner. And they range from things such as mandated worker's comp and safety measures and public health measures to small State oriented issues that constantly put a burden on the small business person.

Now the Federal Government has come along with COBRA and further complicated this matter and made the employer the primary payer and Medicare the secondary in Medicare situations, and this just continues to exacerbate the situation.

I believe we need to provide incentives for small business to offer coverage rather than have inflexible mandated benefits.

I would like to describe for you what we do at the New Castle Chamber of Commerce and why I think this is pertinent to the discussion today. We provide medical coverage for our members. About 60 percent of our members have taken advantage of that coverage, the other 40 percent choose to get their medical coverage elsewhere. We provide two levels of indemnity insurance, a high level which has a $100 deductible and a lower level which has a $300 deductible plan, and then we provide an HMO also. So that any member that joins the Chamber can become involved in this plan and provide these benefits to their employees.

We notice as we send out the bills and receive the funds that we then pass on to the carrier that the money is coming almost exclusively from the employer, not from the employees, they are providing this benefit rather than asking the employee to pay a portion of it, although we have seen a trend in the recent past to have the employer ask the employee to take on about 20 percent of the cost. We think that trend will grow as the costs continue to escalate.

I notice that some of the proposals that are involved and being talked about here in Washington say that mandated health insurance would have $150 deductible. To me that is not a very practical level in the market today. We provide a $300 deductible. It is one of our most popular insurance plans because it has a premium that within Delaware is affordable. The $100 deductible is $35 to $40 more per family, the HMO is $50 more per family. So we see the smaller business people trying to keep costs in line gravitating toward this higher deductible.

I really question if the Federal Government were to mandate a $150 deductible plan over 35 million people, whether or not it would be actuarially sound and what the price of it might be.

I would also like to stress that Congress needs to recognize that mandated benefits will increase labor costs and hurt our competitiveness. And in this sense, I would like to talk about my own private business with is called the Stop Smoking Center. In this business we offer to assist people who want to stop smoking and provide them with a means to stop smoking, and we guarantee it. We put them through in five days an aversion therapy method and we guarantee that they will stop smoking and stay off for a year or we will give them their money back. We employ two part-time employees who are instructors. This is our first full year of operation ending 3 months ago and we were at a slight loss. This year we are on a break-even basis. I believe we may see some profitability in 1988. This is not unusual for a small business to get started and take 2 or 3 years to show profitability.

If we were forced into mandated health care benefits for these individuals, it would extend that period of time to which we hope to meet profitability probably into 1989. I would see probably somewhere in the neighborhood of $6,000 additional expenses in this particular business.

Next, by July I hope to open a coin operated laundry. The contractors are busy today digging holes and whatever contractors do to get things going. We will employ one manager and probably three or four part-time people to fill in the many hours that we plan to be open. This operation also will operate mostly with part time people such as we have heard from the previous person that testified from the small—NFIB—because it is economically the best way to get started for one thing, and then to maintain a profit picture, is to have a certain number of your people on a part-time basis.

If I were to underwrite medical plans for these individuals, probably five in all, it would change my profitability picture severely. It would put me back probably a year or year and a half from now to start seeing a profit or at least a decent cash-flow and cost me somewhere in the neighborhood of $10 to $12 thousand, depending on whether or not the people needed individual coverage or family coverage and what might be mandated. The variables of course we do not know at this point.

I would also like to mention one of my good friends owns four McDonald's in the State of Delaware, he is having a difficult time getting part time people, he is about 80 people short of what he needs to full man those McDonald's. I talked to him before I came here about the cost of mandated health coverage. As you know, McDonald's and similar chain operations tend to hire young people or older people. They are people who are not necessarily looking for health care benefits but he says that if this is mandated of him, that he can see the price of hamburgers going into the $4 range very quickly and making it almost non-competitive to go and buy a hamburger at McDonald's or anywhere else.

Senator **Bumpers**. Well, I certainly do not want to pay $4 for a hamburger. [Laughter.]

Mr. **Rohm**. I believe Congress should apply a cost/benefit analysis to any proposal that they mandate, if they choose to mandate. Some States have done this. I do not think it will prejudice the merits of any proposal but will allow Congress to weigh the tradeoffs of these type of things.

In summary, I would like to say that I think that businesses can pool their efforts though Chambers of Commerce and through associations. They can get out and offer the same kind of thing that we offer through the New Castle County Chamber of Commerce. They are just beginning to realize that they need to do this because of the pressure that has been put on them both through COBRA and because of the escalating costs in health care insurance. I think a State pooling which has been used in some dozen States or so now is also a way of involving the public social sector in this problem and encompassing those people who might fall into that area and getting them involved.

I look forward to working with your committee in any way to help you in this, and I will be glad to answer any questions.

[The prepared Statement of Mr. Rohm follows:]

Statement of the Chamber of Commerce of the United States

ON: MANDATED HEALTH BENEFITS AND SMALL BUSINESS HEALTH COVERAGE

TO: SENATE COMMITTEE ON SMALL BUSINESS

BY: FREDRIC M. ROHM

DATE: APRIL 23, 1987

The Chamber's mission is to advance human progress through an economic,
political and social system based on individual freedom,
incentive, initiative, opportunity and responsibility.

The U.S. Chamber of Commerce is the world's largest federation of business companies and associations and is the principal spokesman for the American business community. It represents approximately 180,000 businesses and organizations, such as local/state chambers of commerce and trade/professional associations.

More than 91 percent of the Chamber's members are small business firms with fewer than 100 employees, 58 percent with fewer than 10 employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

Besides representing a cross section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business--manufacturing, retailing, services, construction, wholesaling, and finance--numbers more than 11,000 members. Yet no one group constitutes as much as 29 percent of the total membership. Further, the Chamber has substantial membership in all 50 states.

The Chamber's international reach is substantial as well. It believes that global interdependence provides an opportunity, not a threat. In addition to the 56 American Chambers of Commerce Abroad, an increasing number of members are engaged in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on national issues are developed by a cross section of its members serving on committees, subcommittees and task forces. Currently, some 1,800 business people participate in this process.

STATEMENT
on
MANDATED HEALTH BENEFITS AND SMALL BUSINESS HEALTH COVERAGE
before the
SENATE COMMITTEE ON SMALL BUSINESS
for the
U.S. CHAMBER OF COMMERCE
by
Fredric M. Rohm
April 23, 1987

Mr. Chairman and members of the Committee, my name is Fredric M. Rohm. I am President of the New Castle County Chamber of Commerce in Newark, Delaware, a chamber of commerce whose membership is predominately small businesses. I am also a small businessman, the owner of "Stop Smoking Center, Inc.," which specializes in helping people quit smoking through the aversion therapy method. I serve as a member of the U.S. Chamber of Commerce's Health Care Council, and I am pleased to appear here today on behalf of the Chamber to discuss mandated health benefits.

In brief, the Chamber supports the present system of voluntary, nondiscriminatory, private sector employee health care benefit plans which can vary in accordance with the needs of employers and employees. We oppose federal or state government requirements mandating plan design or financing, whether applicable to insured or self-insured plans, because they limit flexibility and raise costs. Furthermore, if Congress decides to embark on this major change in policy, fairness to all affected parties demands that there first be a thorough policy debate, similar to the one preceding enactment of federal restrictions on retirement plans.

The Success of the Voluntary Health Care System

In recent years, there has been increased attention paid to the real problem faced by millions of Americans who lack health care coverage. It is appropriate that attention be focused on this issue because lack of coverage is a real concern. The Employee Benefit Research Institute reports that, of the approximately 35 million Americans without health care coverage perhaps 19 million are people who hold jobs, and several million more are the dependents of workers. This problem is an appropriate area of inquiry for this Committee because the employees of small businesses are less likely to have coverage than the employees of larger firms.

The U.S. Small Business Administration reported that in 1983, 39 percent of businesses with fewer than 25 employees had health coverage, compared to 85 percent of firms with more than 500 employees.

However, before we discuss in greater detail the lack of health care coverage--and various suggested methods of addressing the problem--it is worthwhile to reflect on the level of health care coverage already provided by businesses under the auspices of our voluntary private-sector system.

American businesses provide health care coverage to 132 million people, which represents 84 percent of the total private health care coverage in the nation. In 1985, the total health care expenditures of American businesses was $105 billion. That amount does not include the additional portion of public health expenditures that businesses, as taxpayers, helped finance.

As health care costs have risen over the past decade, business, as the purchaser of health care on behalf of most working-age Americans and their dependents, has taken an active role in the improvement of health insurance plans to assure the delivery of quality care in the most efficient manner. Central to these efforts has been the stimulation of competition in providing health care by offering workers choices of delivery systems.

Employee group health care benefit plans vary greatly, covering a variety of health services and requiring different levels and types of employee cost-sharing. Within the limits of their business economic circumstances, employers have the flexibility to design plans tailored to the preference of their work force. At unionized firms, the scope of health care benefits is the subject of collective bargaining.

The Growth of State-Mandated Benefits

Historically, various groups have advocated minimum requirements for benefit levels, elements of coverage, or rules for reimbursement for particular categories of health care providers. However, Congress rejected that approach when it enacted the Employee Retirement Income Security Act (ERISA) in 1974. ERISA includes provisions preempting state regulation of welfare benefit plans, such as employee group health care benefits.

In June 1985, in Metropolitan Life Insurance Co. v Massachusetts, the U.S. Supreme Court ruled that the states' right to regulate insurance outweighs the ERISA preëmption provision. As a result, the states now are free to apply their benefit mandates to all health care benefit plans that are financed through insurance arrangements, affecting about two-thirds of covered workers. However, ERISA still protects self-insured plans from such mandates.

All states have enacted some type of mandated health benefit. Typically, mandates include extensions of eligibility of coverage to various classes of beneficiaries or requiring health plans to cover treatment for alcoholism, drug abuse, or mental problems or to reimburse for treatment by particular health professionals. These state mandates now number well over 600. A chart listing the various state mandated benefits is shown in the Appendix to this statement.

The Metropolitan decision creates difficult choices for insurance companies. They may provide nonuniform plans at a greater administrative expense or provide one plan which incorporates all the benefits mandated by differing state laws. Pursuing the latter course undoubtedly will increase the price of health insurance for many businesses. In addition, if states pass contradictory requirements, uniform benefit plans would be possible only if the insurance carrier withdraws from certain states. Since small businesses have fewer resources to assume the risk of self-insuring, those that do want to provide health coverage for their employees are most likely to purchase it from insurance companies. Accordingly, additional state mandates, which raise the cost of insurance, present further impediments for smaller companies to afford coverage and this exacerbates the problem of lack of coverage. The Chamber urges the Congress to legislatively overturn the Metropolitan decision. We note that this is consistent with the request of the delegates to the White House Conference on Small Business last August, that Congress act to prevent states from mandating benefits.

The Growth of Federally-Mandated Benefits

Until very recently, the trend toward mandated health benefits remained largely a state law phenomenon. For decades, the only benefits that employers were required by federal law to provide were: Social Security, unemployment insurance, and workers' compensation.

As the federal budget deficit has grown there has been a shift in philosophy toward having the business community pay health care costs heretofore borne by federal programs. For example, a series of budget reconciliation measures in recent years has made employer-sponsored plans the primary payor (and Medicare the secondary payor) for coverage of workers over age 65, their spouses and, most recently, for certain disabled workers.

Perhaps the most blatant example of an ill-advised federal mandate was the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which contained provisions requiring employers to continue to make available health care plans to various categories of former employees and their family members for periods ranging from 18 to 36 months. Those "continuation of coverage" provisions were attached to the reconciliation measure with virtually no open Congressional discussion.

Although the continuation of coverage under COBRA is made available at the beneficiary's own expense, simply complying with COBRA is an administrative burden for many companies. Moreover, the likelihood that those individuals who are the most frequent users of health care coverage will be the most likely to continue that coverage--with the commensurate increase in insurance premiums due to the adverse selection--belies the claim that COBRA involves no cost to employers. The fact is: COBRA and other federal cost-shifting to business has been a powerful incentive for companies to discontinue or reduce health care or other employee benefits.

The most recent evidence of federal health care mandates has been the effort to require all states to establish high risk health insurance pools. Ostensibly, these state risk pools would permit individuals who are unable to obtain coverage, due to their medical conditions, to purchase that coverage through the pool. Already, states have created such pools and the Chamber believes that these state pools may be one appropriate response to lack of coverage for medically-uninsurable people. However, the proposed federal legislation (which passed the House of Representatives last year as part of the Omnibus Budget Reconciliation Act of 1986) would direct all states create up such pools and would require all employers to subsidize the pools' financial shortfall. At the same time, no viable cost containment features would be applied to the operation of the pools.

We urge the Congress to assess carefully the operation of the existing state pools before requiring their establishment nationwide.

Mandatory Health Care Coverage

As troublesome as COBRA and state-mandated coverages have been, at least they have been confined to those businesses that have taken on the expense and function of offering health benefits to workers and their family members. Now, however, even that degree of choice for employers is in danger of being lost. Senator Edward Kennedy (D-MA) is developing a proposal to require all employers to provide a comprehensive health care coverage plan to all employees. Although all the details of the legislation being developed are not known, suffice it to say that a number of the proposed provisions (e.g. deductibles of $150/year (individual) and $300/year (family); no deductibles or copayments for prenatal, well-baby, and child preventive care), are much more generous than what is commonplace among most employer-sponsored plans--including some of the nation's largest companies.

However, the real concern is not just with the particulars of the proposed federally mandated plan but rather, in the mandated approach itself. The proponents of mandated benefits do not seem to realize that many businesses simply cannot afford the added burden of providing a generous array of health care benefits. Health care coverage is less extensive among smaller firms, in part, because very often the quid pro quo for offering health care coverage is not hiring additional workers, or not offering some other important benefit or wage increase, or, in the extreme, simply going out of business. In fact, the concern over mandated benefits, made opposition to such mandates the number two priority at last year's White House Conference on Small Business.

Nor is the concern with federal health mandates confined to the small business sector. Large companies have made the greatest strides to contain rising health care costs. Large and small businesses alike have reason to fear health care cost escalation, once the federal government is in a position to dictate the design of health plans. This fear is confirmed by the cost increases in coverage of benefits required under state law.

What is most unusual about the development of mandated health benefits legislation is that it is gaining popularity at the same time that virtually everyone is decrying the state of American competitiveness. It is time for the proponents of mandated benefits to recognize that the added labor costs incurred as a result of benefit mandates has a real and palpable impact on a company's balance sheet. More mandates could cost American workers the most important benefit of all: a paycheck.

Alternatives to Mandated Benefits

The Chamber and the business community share the public's concern over the problem of lack of health care coverage which has fostered the mandated benefits proposals. Accordingly, we offer a number of possible solutions to the problem of gaps in health care coverage.

First, Congress must recognize that the population of uncovered individuals is varied. Some are unemployed and cannot be aided directly by employer-sponsored coverage. For them, effective public programs and opportunities for Medicaid "buy-in" plans may be an appropriate alternative. Others who lack coverage are young people with the means to purchase coverage but whose good health status makes coverage a low priority. For them, further education regarding the importance of coverage is vital.

For the employees of small businesses where gaps in coverage are the greatest, a variety of solutions exists. First, an expansion of the 25 percent deduction now available to self-employed individuals may prove helpful. Self-employed persons should have a complete deduction in order to have greater parity with employees who receive tax-exempt, employer-sponsored coverage.

Secondly, much can be done to encourage the expansion of health care plans that can be offered through chambers of commerce, trade or professional associations, or other business groups, such as Multiple Employer Trusts (METs). The New Castle County Chamber of Commerce has a very extensive health care insurance program available to its members. We have been able to offer small businesses the opportunity to purchase health care coverage at competitive rates. Approximately half of the members of our local chamber purchase health care coverage through the New Castle County Chamber. Most of the other members offer health care coverage to their employees through other means. In all, about 1000 companies carry the chamber's health care plan and offer coverage to 2,600 workers.

As you readily can see, our Chamber is helping to close the gaps in coverage for precisely the small businesses which most often have difficulty obtaining coverage. Encouraging the kind of program we offer to small firms, rather than mandating an inflexible program to all companies, would be a welcome first step by the federal government.

Finally, we offer advice on steps that may be taken legislatively to slow the apparently inexorable trend toward mandated benefits. We encourage Congress to follow the lead taken by some states that have witnessed how state-mandated benefits cause escalating health care costs. Some states such as Arizona, Nebraska, Oregon, Pennsylvania and Washington, have applied cost/benefit analysis to state-mandated benefit laws. This analysis prevents the state legislature from enacting such measures until the true costs of the mandate--and the alternatives to the mandate--are explored more thoroughly. The advantage of such an approach is that it does not prejudge the merits of any mandated benefits proposal; it merely requires an honest assessment of the pros and cons of such proposal. Senator Dan Quayle (R-IN) has suggested a similar approach for federal legislation that is considered by the Senate Committee on Labor and Human Resources, and we strongly recommend this approach by which Congress can assess the costs of mandated benefits.

Conclusion

The Chamber strongly supports the voluntary private-sector employee benefits system. Within that system, there are several opportunities for expanding health care coverage to employees of small businesses. Mandating health care benefits reduces employer/employee flexibility, imposes costs that diminish American competitiveness, and imposes costs that are too expensive for many small firms to bear. The Chamber strongly urges Congress to apply a serious cost/benefit analysis to the various mandated benefits proposals it considers so that the impact of such proposals can be assessed more carefully.

APPENDIX

MANDATED COVERAGE LAWS

ENACTED THROUGH DECEMBER 1986

Prepared by: BCBSA
Greg Scandlen and Brenda Larsen
Office of Government Relations
State Services
February 10, 1987

MANDATED COVERAGES

	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA
NURSES										
Nurse Midwives		83	85				84		83	
Nurse Practitioners			85				84			
Nurse Anesthetists			85				84			
THERAPISTS										
Physical							75			
Occupational					78		82			
Speech/hearing				**85**	78					
COUNSELORS										
Psychologists	82		83	75	80	79	75			80
Psychiatric Nurses					82		84			
Social Worker					76		79			
DENTISTS	75	83	77		76		75			
ORAL SURGEONS										
OPTOMETRISTS	67	83			80		75	X*	74	
PODIATRISTS	76			75	76			X*	74	
CHIROPRACTORS	75	83	83		76		71	X*	76/86	80
OSTEOPATHS		83								
OTHER				75	76		75/84			
ALCOHOLISM	79		79		**78**	76	74/77		79	
DRUG ABUSE			79				76		79	
MENTAL HEALTH			79	**83**	73	76	75/82		76/83	81/84
BREAST RECONSTRUCTION			81	78	78					
MATERNITY				76	76	75	76			78
PRESCRIPTION DRUGS							75			
ORTHOTIC AND/OR PROSTHETIC DEVICES					**85**					
CLEFT PALATE										
DIABETIC EDUCATION					**81**					
DIABETIC OUTPATIENT										
SECOND OPINION										
HOME HEALTH			82		**78**	**84**	75/76			
HOSPICE						**84**	76			
LONG TERM CARE										
AMBULATORY SURGERY			71						77	
ANTI-ABORTION						**85**	82			
PUBLIC INSTITUTIONS										
AMBULANCE/TRANSPORT FOR NEWBORNS										
PREVENTIVE CARE FOR CHILDREN/INFANTS					**74**				86	
OTHER HEALTH CENTERS										
DEPENDENT STUDENTS							82			79
ADOPTED CHILDREN			85						85	
NEWBORNS	75	75	74	75/83	71	75	74	74	80/84	74
MENTALLY/PHYSICALLY HANDICAPPED			77	69	71		71		70	72
NON-CUSTODIAL CHILDREN							84			
CONVERSION PRIVILEGE			85	79/85	83		75			
CONTINUATION FOR DEPENDENTS			85	85	76		75/76			80/81
CONTINUATION FOR EMPLOYEES				85	77/**84**	86			75	86
CATASTROPHIC COVERAGE										
MANDATE EVALUATION			85							

X = Year unknown

* = Commercials only

Bold Print = Mandated offerings

02/10/87

MANDATED COVERAGES

	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD
NURSES										
Nurse Midwives								84		79
Nurse Practitioners										79
Nurse Anesthetists										84
THERAPISTS										
Physical										
Occupational										
Speech/hearing										
COUNSELORS										
Psychologists	84			85		74		75	75	73
Psychiatric Nurses									83	83
Social Worker						**82**			83	77
DENTISTS	74			74		73		74	75	
ORAL SURGEONS										
OPTOMETRISTS			80	74	**83**	73			82	73
PODIATRISTS			81 *	74		73				73
CHIROPRACTORS				74	86	73	**80**/86	75	86	73
OSTEOPATHS										73
OTHER			82							
ALCOHOLISM				76		86	**78**	**80**	**74**	82 80
DRUG ABUSE						**78**/86		**80**	83	78
MENTAL HEALTH			**74/77**			**78**/86	**86**	**75**	79/83	73/86
BREAST RECONSTRUCTION			80							
MATERNITY	74								75	75
PRESCRIPTION DRUGS									83	
ORTHOTIC AND/OR PROSTHETIC DEVICES										78
CLEFT PALATE		85		85						82
DIABETIC EDUCATION					**84**					
DIABETIC OUTPATIENT										
SECOND OPINION										85
HOME HEALTH							**82**		77	79
HOSPICE										82
LONG TERM CARE							86			
AMBULATORY SURGERY	74						78			
ANTI-ABORTION							78			
PUBLIC INSTITUTIONS										67
AMBULANCE/TRANSPORT FOR NEWBORNS								80		
PREVENTIVE CARE FOR CHILDREN/INFANTS										
OTHER HEALTH CENTERS				85					79	76
DEPENDENT STUDENTS								78		79
ADOPTED CHILDREN			81							79
NEWBORNS	74	74	75	76	74	74	76	73	76	77
MENTALLY/PHYSICALLY HANDICAPPED	68	72	67	69/86				72		X
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE			83		86	78/80	74		82	79
CONTINUATION FOR DEPENDENTS			76/85		86	78/84	80			77
CONTINUATION FOR EMPLOYEES	74	75	84		86	84	80	83	83/**86**	79
CATASTROPHIC COVERAGE										78
MANDATE EVALUATION										

X = Year unknown

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Bold Print = Mandated offerings

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MANDATED COVERAGES

	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ
NURSES								85		84
Nurse Midwives			83	80			84			82
Nurse Practitioners				80					85	
Nurse Anesthetists			83	80						
THERAPISTS										
Physical										75
Occupational										
Speech/hearing					**84**					
COUNSELORS										
Psychologists	75	68*	75	74	83	81	74	80	75	73
Psychiatric Nurses	86									
Social Worker	82					85			83	
DENTISTS	75		73	74	78	83	75	75		79
ORAL SURGEONS		85							75	
OPTOMETRISTS			73	66	78		69	75		67
PODIATRISTS			73		79		69	75		
CHIROPRACTORS		79	73	80	78		67	82		80
OSTEOPATHS							67	75		
OTHER					78			75		
ALCOHOLISM	73	74/82	73/82	74	77/85	79	80	83		77
DRUG ABUSE		74/82	73/82		80	81		83		
MENTAL HEALTH	73/82		75		80	81			75/83	
BREAST RECONSTRUCTION		85	80					83		83
MATERNITY			73		73			77		
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES		85								
CLEFT PALATE										
DIABETIC EDUCATION										
DIABETIC OUTPATIENT										
SECOND OPINION										80
HOME HEALTH	86					**81**		75		
HOSPICE		**84**						83		
LONG TERM CARE										
AMBULATORY SURGERY		84/85	76		75/81					
ANTI-ABORTION					83					
PUBLIC INSTITUTIONS			73			73	84			
AMBULANCE/TRANSPORT FOR NEWBORNS				79						
PREVENTIVE CARE FOR CHILDREN/INFANTS										
OTHER HEALTH CENTERS										
DEPENDENT STUDENTS							76			
ADOPTED CHILDREN	75		83							
NEWBORNS	74		73	74	74	73	75	76	75	75
MENTALLY/PHYSICALLY HANDICAPPED	56	66	69	72		71		76	69	66
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	76		77		81	81	78	80		
CONTINUATION FOR DEPENDENTS			73/77		69		80	80	81	76/80
CONTINUATION FOR EMPLOYEES			73		85	81	79			82
CATASTROPHIC COVERAGE			76							
MANDATE EVALUATION							86			

X = Year unknown

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Bold Print = Mandated offerings

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MANDATED COVERAGES

	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC
NURSES		**84**						86		
Nurse Midwives	85	82			84	71		32		
Nurse Practitioners				**84**			80	86		
Nurse Anesthetists								86		
THERAPISTS										
Physical		73								
Occupational										
Speech/hearing										
COUNSELORS										
Psychologists	77	71	77		74	71	76	78		
Psychiatric Nurses										
Social Worker		85								
DENTISTS	77	75			73	71	71			
ORAL SURGEONS										
OPTOMETRISTS	77	X			80	71	76	78		85
PODIATRISTS	77	X			80	71				72
CHIROPRACTORS	84	X	73	79	80	71		**81**		**80**
OSTEOPATHS	77				80					
OTHER	85									
ALCOHOLISM	**83**	82/83	**84**	75	78		75/81	86	80	
DRUG ABUSE			**84**	75						
MENTAL HEALTH		77		75	83		73			
BREAST RECONSTRUCTION		75								
MATERNITY		76			79		73			
PRESCRIPTION DRUGS								*		
ORTHOTIC AND/OR PROSTHETIC DEVICES										
CLEFT PALATE			82							
DIABETIC EDUCATION										
DIABETIC OUTPATIENT										
SECOND OPINION		76							83*	
HOME HEALTH	77	72/75							84*	
HOSPICE		**85**								
LONG TERM CARE										
AMBULATORY SURGERY		X				76				
ANTI-ABORTION				79				82		
PUBLIC INSTITUTIONS			75		76					
AMBULANCE/TRANSPORT FOR NEWBORNS	75									
PREVENTIVE CARE FOR CHILDREN/INFANTS		82								
OTHER HEALTH CENTERS		X								
DEPENDENT STUDENTS										
ADOPTED CHILDREN										
NEWBORNS	75	77	73	79	74	**84**	75	76		74
MENTALLY/PHYSICALLY HANDICAPPED	69	65	69/73	**82**	71			68		70
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	83	71/81	82	83	75/**84**		77		78	78
CONTINUATION FOR DEPENDENTS	83	81	83						83	78
CONTINUATION FOR EMPLOYEES										
CATASTROPHIC COVERAGE									74	
MANDATE EVALUATION							85	86		

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MANDATED COVERAGES

	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
NURSES							81			
Nurse Midwives	80			79			81	83		
Nurse Practitioners	80						81			
Nurse Anesthetists										
THERAPISTS										
Physical										
Occupational										
Speech/hearing			83							
COUNSELORS										
Psychologists	86	74	77	75		77				85
Psychiatric Nurses								77		
Social Worker		**85**		75		**79**				
DENTISTS		74	83						75	
ORAL SURGEONS										
OPTOMETRISTS		65	79	75		77			75	
PODIATRISTS		65	77	75		79	83		75	
CHIROPRACTORS		81	79	75		79*	**83**		76	
OSTEOPATHS			**58**			77				71
OTHER	80	82				77				
ALCOHOLISM	79	**79**	81	81	82/85	77/80	74	82	74/85	
DRUG ABUSE			81			**77/80**			74/85	
MENTAL HEALTH		**79/80**	81		76	76/77	**83**	77*	74/86	
BREAST RECONSTRUCTION							83/85			
MATERNITY		84	77			78			82	
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES										
CLEFT PALATE										
DIABETIC EDUCATION									84	
DIABETIC OUTPATIENT				84					82	
SECOND OPINION										
HOME HEALTH					76		**83**		78	
HOSPICE							**83**			
LONG TERM CARE								86		
AMBULATORY SURGERY				76						
ANTI-ABORTION										
PUBLIC INSTITUTIONS									80	75
AMBULANCE/TRANSPORT FOR NEWBORNS										
PREVENTIVE CARE FOR CHILDREN/INFANTS										
OTHER HEALTH CENTERS			83						75	
DEPENDENT STUDENTS										
ADOPTED CHILDREN	83			85						
NEWBORNS	76	74	73	77	76	76	74/84	75	76	75
MENTALLY/PHYSICALLY HANDICAPPED		69	81	75		74	69		75	71
NON-CUSTODIAL CHILDREN										
CONVERSION PRIVILEGE	79	80	77	79		82	84		80	83
CONTINUATION FOR DEPENDENTS	80	86	79		84		80	83	80	
CONTINUATION FOR EMPLOYEES							73	82	73/80	
CATASTROPHIC COVERAGE										
MANDATE EVALUATION							84			

Y = Year unknown

* = Commercials only

Bold Print = Mandated offerings

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MANDATED COVERAGES

Miscellaneous

AR - Outpatient Diagnostic: Licensed Health Professionals (75)

AZ - Maternity benefits for natural mother of an adopted child on adopted parents policy (86)

CA - Sterilization (70); Prenatal Care (76,79); Child/Family Counselors (80,81); Acupuncture (84); Psychiatric Health Facility (84)

CT - Notice of Termination (82); Nutropathic Medicine (75); most passed under comprehensive health care act of 1975; HMO Rehabilitation Facilities (82); Emergency Ambulance Services (83); Home Health Aides; (84) Home Health Aides under Medicare supplement policies (86)

CO - Anti abortion mandate for state group only (85)

HI - Prepaid Health Care Plans (74)

ID - Complications of Pregnancy (76)

IL - Raped or Sexual Assault (75,82); Psychologists Mandated Through Regulation (76); Liver Transplants (84); All persons licensed under medical practice act are entitled to reimbursement if legally able to provide contract benefit (82)

KY - Newborn Nursery Care (80); Nursing Home (86)

LA - Non-group to age 65 (74)

MD - Partial Psychiatric Hospitalization (76); Blood Products (75); All Providers (8[illegible] Orthopedic Braces (78); Invitro Fertilization (85); OP benefits resulting from UR programs (85)

MI - Non-group Medicare Complimentary Coverage (85); Mental Hospitals (83)

MS - Pre-existing Conditions (82)

MO - Pharmacists (78)

MT - Professional Counselors (85); Denturists (85)

NH - Pastoral Counselors (83)

NV - Chinese Medicine (75)

NJ - Diagnostic X-rays by Chiropractors (76)

NY - Pre-admission Testing (76); Ambulance Cancer Treatment (82); Nursing Home Option (X)

ND - Continued Coverage after HMO Selections (83)

NM - Practitioner Mandates of 1977 do not apply to Plan; Lay Midwives (85)

OH - OP Dialysis (72)

OR - Denturists (80)

SD - Reimburse all "Healing Arts" Practitioners (80); COB Prohibitied (81)

TN - School Psychologists (82)

TX - OP Psychiatric Centers (83)

VA - Opticians (77); Termination Notice (82); Mandated Benefit Option (82)

WI - Tuberculosis; Skilled Nursing Homes (75); COB (80); Kidney Disease (74)
Insulin Infusion Pumps (81)

WY - Licensed Practitioners (71)

Senator **Bumpers**. Thank you, Mr. Rohm. First of all, Mr. Jenkins, I used to be a hardware store operator too.

Mr. **Jenkins**. Terrific.

Senator **Bumpers**. I had four employees and I had health coverage but my employees had to pay for all of it, I did not pay for any of it. And I wish I could have contributed to their health plans, but I was having a tough time just keeping the doors open.

Mr. **Jenkins**. Absolutely. I know exactly what you are talking about.

Senator **Bumpers**. If I had been burdened with mandatory coverage I would have had to shut the door.

Senator Kennedy has been talking about mandated health coverage for all employees. At this stage of the game I do not see how that is a workable idea, no matter how laudable that might be and how much we would like to see all these people covered. It is a national disgrace that 30 to 37 million Americans have no health coverage, but I'm not sure mandating that coverage is the best approach.

Mr. **Jenkins**. It isn't. Placing the burden on the small business to provide when the employee may not want the coverage—I from time to time employ part time people and they are not the least bit interested in this employee benefit, they want the money in their paycheck. Maybe it is the feeling of invincibility that youth gives you, but they just do not believe they are ever going to need it.

Senator **Weicker**. Excuse me, if you will yield on that point. The problem is if anything does happen, then who do you think has to pick up the tab? The Nation is not going to sit by and watch these people die or be dumped off into the gutter; that is what we are talking about here. What happens when these people get hurt or get sick?

Mr. **Jenkins**. One of the things that was not brought up in my testimony, a problem I ran into in trying to secure coverage. Because I have a small firm, I do not carry workers' compensation, it is not required for a firm of my size.

Senator **Bumpers**. It is not required?

Mr. **Jenkins**. Not in North Carolina, no, sir, not a firm my size.

Senator **Bumpers**. Pardon me.

Mr. **Jenkins**. Certainly.

Senator **Bumpers**. What is the limit on workers' compensation in North Carolina?

Mr. **Jenkins**. I believe it is five employees or more. Without exception every one of the contracts that I looked at had a stipulation that they would not cover accidents or illness that were job related, what workers' comp would normally cover. So it puts me in a position that if I am to buy this particular type of coverage, I have to have workers' comp also.

Senator **Bumpers**. Do you carry workers' comp?

Mr. **Jenkins**. No, sir, I do not.

Senator **Bumpers**. You have got a pretty good exposure there, have you not?

Mr. **Jenkins**. Yes, sir, I do. And I probably will as I add another employee, I will have to pick up workers' comp.

Senator **Bumpers**. Mr. Rohm, has New Castle ever offered any kind of a health promotion program such as a quit smoking campaign in an effort to reduce your health insurance premiums?

Mr. **Rohm**. Right now we are doing a walk-a-thon program that we hope to involve the whole county in.

Senator **Bumpers**. Newark, is that the name of it?

Mr. **Rohm**. (Pronouncing) New Ark.

Senator **Bumpers**. I have often wondered why it is New Ark in Delaware and Newark in New Jersey. We have Poughkeepsie in Arkansas and we have Poughkeepsie in New York.

Mr. **Rohm**. For probably the same reason. [Laughter.]

Senator **Bumpers**. Senator Weicker.

Senator **Weicker**. No questions of these witnesses.

Senator **Bumpers**. Senator Harkins.

STATEMENT OF HON. TOM HARKIN, A U.S. SENATOR FROM THE STATE OF IOWA

Senator **Harkin**. I have no question so much as, I guess, an observation based on what Senator Weicker said. It is true that those people—I went through an experience in my own family—not my immediate family but relatives of mine—that were out of work and not having any kind of health coverage. And it occurred to me then a couple of things; number one, I can see the problems in small businesses of mandating health coverage. I mean literally it will cause a lot of them to close their doors, while otherwise they might be able to go ahead and compete and run a viable small business in small communities like the community that I come from in Iowa. On the other hand, we do have a societal responsibility to insure that people have some form of health care coverage so that they are not dumped out on the streets.

My problem is that while I tend to agree I think with the Chairman and probably your position that mandated health care coverage for all businesses in America would simply be devastating to small businesses; on the other hand, I hope to see from the small business community some support for some form of comprehensive health care insurance that would be paid for out of general revenues that we would all tend to pay for in some form, that would give comprehensive health care insurance coverage to the very people we are talking about. Because it is a societal problem and rather than having you bear the burden yourself, I think that all of us ought to bear that burden. And I guess what bothers me is when I hear small businesses say no, we do not want mandated health care coverage, and I tend to agree with that. Then we say but we have got to do something with some kind of health care coverage for these people. They say well no, not that either.

You see what I am talking about? We have got to do something.

Mr. **Rohm**. Senator, could I comment on that?

Senator **Harkin**. Sure.

Mr. **Rohm**. I think you make a very good point on that and that is exactly what we have tried to address with our Chamber of Commerce. We are trying to provide cost-effective health care for our members and anyone who wishes to join and become a member, provided they are a business. I think that if we had a national effort to get the Chambers of Commerce, the business associations and other trade groups involved in health care coverage and we stress that for the next 2, 3, 5 years, whatever it might take, we could very substantially reduce this number, this 35 million number, down to something that is much more manageable. We could also identify who those people are and we would be in a better position to look at State pooling or other methods of bringing them into the system. The 35 million number is so broad, so all encompassing, it is hard to believe that we could come up with a program that would be effective—cost effective or even get everybody involved.

Senator **Bumpers**. If the Senator would yield, I might make one observation. Some hospitals and doctors are taking care of the uninsured for little or no compensation because they do not have any choice, and it may be that the rest of us are already paying for part of the cost of that care in increased health care costs.

Mr. **Jenkins**. Mr. Chairman, if I could, one of the ideas that I keep hearing people talking about is encouraging small businesses to provide coverage through tax incentives, the 25 percent deductibility, the 50 percent deductibility depending on what your level of employment and the organization of your company. An idea that I think is very interesting is rather than giving a tax credit as it were, is to provide a credit against payroll taxes. That improves my cash flow as opposed to improving profitability. In a small firm like mine, cash flow is more important than profitability at the end of the year. I need to be able to pay the bills all through the year. I do not have anything specific but that may be something to look at.

Senator **Bumpers**. Just going back, Senator Harkin, to a point I made a moment ago. I have a close interest in the Children's Hospital in Little Rock and I know that from about 1980 to 1984 their percentage of charitable care doubled from 12 to 25 percent and is continuing to escalate. And I think the number of people who are uncovered, who have no health care coverage right now, are continuing to escalate, and that is the reason it is getting put on the front burner. It is becoming a national crisis.

We are going to have a couple of witnesses later on talk about some of the things they have done to deal with the problem of the uninsured population.

Companies which are self-insured, as some big businesses are, do not have to carry all the mandated coverage that a carrier has to. If you are going to write insurance in the State of Arkansas, you have to provide a mandated list of things. But if you are self-insured you do not have to carry any of those things. And obviously those people who choose to self-insure can do it at substantially less cost because they do not have the same coverage.

There are a whole host of things that we could do in a creative way. This idea of allowing businesses to buy into Medicaid is really an ingenious idea, and I think it has possibility.

Senator Harkin.

Senator **Harkin**. That is all I have, thank you.

Senator **Bumpers**. Senator Weicker.

STATEMENT OF HON. LOWELL WEICKER, JR., A U.S. SENATOR FROM THE STATE OF CONNECTICUT

Senator WEICKER. I think the statements of both you and Senator Harkin are right on the mark. What we are really doing here is nibbling away at an overall problem. And whether we are talking about mandated health coverage and how it impacts small business or, over in another part of the Capitol, we are talking about catastrophic illnesses, we are only talking about catastrophic illness as it basically applies to the elderly. We forget the fact that the most catastrophic illnesses are probably those that apply to the very young such as spinal cord injury or other serious inflictions suffered by the young.

I have got to say this, Mr. Chairman, for a long time Senator Javits and I and also Senator Kennedy worked very hard on and every year submitted a national health insurance proposal. And I might add, that the final version of that legislation several years ago was through the private sector, I repeat, through the private sector. I do not want to get the Government in the insurance business; there were many different plans that came through the private sector. Again, I say we are coming at this in bits and pieces but I do not think there is any question as a matter of policy, that we feel and that most Americans feel, that 32 million or more Americans should not be in the position of having no coverage. Nor should X number of Americans, again in the millions, have a type of insurance which is inadequate to cover the illnesses that are occurring.

And I, again working along with Senator Bumpers, the Chairman of this committee, have a complete understanding and sympathy for the very special problems raised toward small business in this matter. I hope that we can work something out because I am afraid that the answer is not that we just turn our backs and go about business as usual. I do not think that is going to suffice. And the examples that both of you gentlemen mentioned, such as, the fact that not only do we have the employees that are not covered for health or disability, but that those employees invariably have children in the family who are also not covered clearly show the magnitude of the problem. And as the population expands, the problem of adequate coverage becomes even greater.

I think both of you, Mr. Jenkins and Mr. Rohm, made very articulate presentations for a point of view that clearly has to be recognized in any legislation that is passed by the Congress.

Thank you, sir.

[The prepared statements of Senators Weicker, Wallop, Pressler, and D'Amato follow:]

OPENING STATEMENT OF
SENATOR LOWELL WEICKER, JR.
ON
HEALTH CARE COST AND AVAILABILITY

MR. CHAIRMAN, I COMMEND YOU FOR CONVENING THIS HEARING TODAY ON THE COST AND AVAILABILITY OF HEALTH INSURANCE FOR SMALL BUSINESSES. THERE IS NO QUESTION IN MY MIND THAT PROVIDING ADEQUATE AND AFFORDABLE HEALTH CARE COVERAGE FOR EVERY AMERICAN CITIZEN IS A MAJOR PROBLEM AND ONE THAT CONGRESS MUST BEGIN TO ADDRESS IN ERNEST. ACCORDING TO SOME REPORTS, FROM 1979 TO 1984 THE NUMBER OF UNINSURED AMERICANS GREW FROM 26.2 MILLION TO 35 MILLION, A ONE-THIRD INCREASE IN FIVE YEARS; THIS NUMBER HAS RISEN TO ABOUT 37 MILLION THIS YEAR. THIS IS AN ESCALATING PROBLEM OF SUCH MAGNITUDE THAT CONGRESS MUST TAKE DECISIVE ACTION NOW.

I AM KEENLY AWARE OF THE CONCERNS OF THE SMALL BUSINESS COMMUNITY WITH RESPECT TO LEGISLATION THAT THE CONGRESS MAY ENACT. EARLIER THIS YEAR, SENATOR KENNEDY AND I MET INFORMALLY WITH A NUMBER OF SMALL BUSINESS REPRESENTATIVES TO DISCUSS THIS PROBLEM. ANY LEGISLATION ADDRESSING THIS ISSUE MUST BE SENSITIVE TO SOME OF THE UNIQUE CONCERNS OF SMALL BUSINESSES.

AND SMALL EMPLOYERS HAVE REASON TO BE CONCERNED. AS WITNESSES LATER TODAY WILL INDICATE, SMALL BUSINESSES USUALLY PAY

MUCH HIGHER PREMIUMS THAN LARGE COMPANIES, MUST HIRE MORE PART-TIME OR TEMPORARY EMPLOYEES TO SURVIVE ON LIMITED CASH FLOW AND CANNOT EXERCISE THE MYRIAD OF OPTIONS THAT BIG BUSINESS CAN, SUCH AS SELF INSURANCE OR QUALIFYING FOR CERTAIN INCOME TAX DEDUCTIONS BECAUSE OF THEIR SIZE.

IN ADDITION TO ESTABLISHING A RECORD OF THE CONCERNS OF SMALL BUSINESSES, TODAY'S HEARING WILL GIVE US A BROAD OVERVIEW OF THE PROBLEM, SOME OF THE CAUSES AND HOPEFULLY PROVIDE SOME SOLUTIONS. WE WILL HEAR FROM REPRESENTATIVES OF THE INSURANCE INDUSTRY AND SMALL BUSINESS TRADE ASSOCIATIONS WHICH HAVE BEEN CREATIVELY INVOLVED IN APPLYING DIFFERENT APPROACHES TO PROVIDING SMALL BUSINESSES WITH HEALTH INSURANCE. FOR EXAMPLE, THE TRAVELERS INSURANCE COMPANY FROM MY HOME STATE OF CONNECTICUT HAS BEEN QUITE INNOVATIVE IN STRUCTURING INSURANCE PLANS THAT EXTEND BEYOND TRADITIONAL COVERAGE. I AM PLEASED THAT MIKE MANLEY FROM THE TRAVELERS WILL SHARE WITH US SOME OF THE COMPANY'S PRACTICES IN DEALING WITH THIS HEALTH CARE PROBLEM.

MR. CHAIRMAN, TO REITERATE, PROVIDING ADEQUATE AND AFFORDABLE HEALTH CARE COVERAGE FOR EVERY AMERICAN CONTINUES TO BE ONE OF MY TOP LEGISLATIVE PRIORITIES. I LOOK FORWARD TO HEARING THE TESTIMONY OF THE WITNESSES TODAY AND THE GROUPS THAT THEY REPRESENT AND TO WORKING WITH THEM IN A REASONABLE FASHION TO PROVIDE SOME RELIEF TO THIS PROBLEM.

STATEMENT OF SENATOR MALCOLM WALLOP
SENATE SMALL BUSINESS COMMITTEE HEARING
ON MANDATED HEALTH BENEFITS
APRIL 23, 1987

I'm pleased that the Small Business Committee is taking the initiative to study the dilemma facing this nation's 35 million uninsured individuals. As most of you here today know, nearly 75 percent of the uninsured in this country earn less than $10,000 a year and over half of those with no health insurance work in small businesses . Clearly, any decisions made by Congress in the health insurance arena will have a major impact on small businesses, particularly in states like Wyoming, where 80 percent of all enterprises are small businesses.

Right up front, I want to state that I have grave reservations about the federal government mandating that businesses provide health insurance coverage for workers. Any one who thinks small businesses could absorb the cost of mandatory health insurance without financial hardship has literally no knowledge of small business. As we all know, small businesses are very fragile. Over twenty percent of all new enterprises fail within a year of startup and the survivors usually don't see any kind of profit for an average of eighteen months. Even successful businesses operate on a thin profit margin. Offering health insurance is a particular problem for them, posing administrative complexities and paperwork burdens in addition to premiums averaging 40 percent higher than large employers pay. An article apprearing in Monday's Washington Post predicted that these rates would rise even more.

Mandated health insurance is, in effect, a tax, that will only increase prices and the number of business failures while absolutely ensuring fewer jobs and lower wages. It will severely damage the growth of small entrepreneurial firms which are the main source of new jobs in this nation. Any type of limited or targeted health insurance -- say, mandating coverage only for workers with children -- could result in peculiar hiring practices such as employing only those without kids. Rather than thrusting mandated health insurance on the small business community, the challenge should rest with private firms to implement innovative, positive incentives to make health care coverage a more attractive option for small business employers.

OPENING STATEMENT BY SENATOR LARRY PRESSLER
BEFORE THE COMMITTEE ON SMALL BUSINESS
HEARING ON THE IMPACT OF HEALTH CARE LEGISLATION ON SMALL BUSINESS
APRIL 23, 1987

I WANT TO BEGIN BY THANKING THE CHAIRMAN FOR CALLING THIS HEARING TODAY. THE ISSUE OF SMALL BUSINESS AND HEALTH CARE IS ONE WHICH IS BOTH TIMELY AND CRITICAL.

THE AVAILABILITY AND AFFORDABILITY OF HEALTH INSURANCE IS A MAJOR PROBLEM WHICH AFFECTS MILLIONS OF PEOPLE IN THIS COUNTRY. ITS IMPACT IS FELT NOT ONLY BY OWNERS AND EMPLOYEES OF SMALL BUSINESSES, BUT ALSO THEIR FAMILIES, THE BUSINESSES THEMSELVES, INSURANCE COMPANIES, AND THE FEDERAL AND STATE GOVERNMENTS. I HAVE BEEN INVOLVED IN SENATE AGING COMMITTEE HEARINGS ON THIS ISSUE, AND I CAN ASSURE MEMBERS OF THIS COMMITTEE THAT THE ANSWERS WILL NOT COME EASILY.

I HAVE HEARD FROM MANY SOUTH DAKOTA SMALL BUSINESS OWNERS REGARDING THIS PROBLEM. THEY ARE EXTREMELY NERVOUS ABOUT THE PROSPECT OF MANDATED BENEFITS. BECAUSE OF THE CURRENT TROUBLED AGRICULTURAL ECONOMY, MANY OF OUR SMALL BUSINESSES, FROM IMPLEMENT DEALERS TO CAFES, ARE BARELY MAKING ENDS MEET. MANY VIEW MANDATED BENEFITS AS THE STRAW WHICH WILL BREAK THE CAMEL'S BACK.

LET ME SAY THAT I KNOW IT IS NOT JUST SMALL BUSINESSES IN RURAL STATES LIKE SOUTH DAKOTA THAT ARE CONCERNED OVER THIS ISSUE. DELEGATES TO THE 1986 WHITE HOUSE CONFERENCE ON SMALL BUSINESS RANKED MANDATED BENEFITS THEIR SECOND MOST IMPORTANT ISSUE. THEY CLEARLY STATED THEIR VIEW THAT THERE SHOULD BE NO FEDERAL GOVERNMENT MANDATED EMPLOYEE BENEFITS. IN FACT, THE CONFERENCE ASKED CONGRESS TO PROHIBIT STATES FROM MANDATING SUCH BENEFITS AS WELL.

AT THE SAME TIME, SOME 35 MILLION AMERICANS WERE NOT COVERED BY HEALTH INSURANCE IN 1985. THIS POSES AN OMINOUS THREAT TO THE WELFARE OF THIS NATION.

ACCORDING TO SMALL BUSINESS ADMINISTRATION FIGURES, ONLY 39 PERCENT OF WORKERS IN FIRMS WITH FEWER THAN 25 EMPLOYEES ARE COVERED BY A HEALTH CARE PLAN. AT THE SAME TIME, SOME 85 PERCENT OF THOSE IN FIRMS WITH MORE THAN 1,000 EMPLOYEES ARE INSURED. WHY IS THERE SUCH A DIFFERENCE IN THE NUMBERS OF INSURED EMPLOYEES BETWEEN SMALL AND LARGE BUSINESSES? MR. CHAIRMAN, I AM CERTAIN WE WILL HEAR SEVERAL ANSWERS TO THIS QUESTION DURING TODAY'S DEBATE, BUT LET ME TOUCH BRIEFLY ON SOME OF THE REASONS.

FIRST, IT SIMPLY COSTS MORE TO UNDERWRITE AND ADMINISTER INSURANCE PLANS FOR SMALL FIRMS. FEWER EMPLOYEES MEANS THERE IS A SMALLER NUMBER OF INDI-

VIDUALS AMONG WHOM TO SPREAD THE RISK. SMALL BUSINESSES EXPERIENCE A HIGHER TURNOVER RATE AMONG EMPLOYEES. THIS ONLY ADDS TO THE COST OF ADMINISTRATION.

SMALL BUSINESSES OFTEN DEPEND A GREAT DEAL ON PART-TIME EMPLOYEES. SINCE IT COSTS AS MUCH TO INSURE THESE INDIVIDUALS AS IT DOES TO COVER A FULL-TIME WORKER, THE HEALTH INSURANCE COST PER EMPLOYEE RISES. FINALLY, LARGER COMPANIES CAN USE THEIR LARGER RISK POOL TO SELF INSURE. THIS IS VERY SELDOM AN OPTION FOR A SMALL BUSINESS.

TODAY'S DISCUSSION WILL LIKELY CENTER ON TWO GENERAL OPTIONS FOR ADDRESSING THE HEALTH INSURANCE PROBLEM. THE FIRST IS FEDERALLY MANDATED BENEFITS. THE SECOND INCLUDES VARIOUS FEDERAL INCENTIVES DESIGNED TO ENCOURAGE SMALL BUSINESSES TO PROVIDE HEALTH CARE PLANS.

I AM A STRONG BELIEVER IN THE PRIVATE SECTOR AND I MUST BEGIN BY SAYING THAT ON ITS FACE, THE CONCEPT OF MANDATED BENEFITS TROUBLES ME. THE COST OF ANY MANDATED COVERAGE OBVIOUSLY WILL BE BORNE BY THE SMALL BUSINESS COMMUNITY. HOW WILL THEY BE PAID FOR? WILL THEY RESULT IN FEWER JOBS OR LOWER WAGES? WILL THEY IN SOME CASES MAKE THE COST OF STARTING A SMALL BUSINESS PROHIBITIVELY HIGH?

IN ADDITION, WHAT LEVEL OF COVERAGE DO WE MAN-

DATE? WILL A SMALL BUSINESS IN SOUTH DAKOTA BE REQUIRED TO OFFER THE SAME HEALTH CARE PLAN AS A SMALL BUSINESS IN NEW YORK CITY? WHAT ABOUT THE RIGHTS OF THE VARIOUS STATES TO GOVERN THEIR OWN INSURANCE LAWS?

THE ISSUE OF PROVIDING INCENTIVES WOULD PERHAPS BE THE MORE WORKABLE SOLUTION. HOWEVER, THERE ARE PROBLEMS TO BE CONSIDERED HERE, TOO. WHILE MANDATED BENEFITS WOULD FORCE SMALL BUSINESSES TO PAY, THE VARIOUS INCENTIVES WOULD BE PAID FOR IN THE FORM OF REDUCED FEDERAL REVENUE.

ANOTHER, AT LEAST PARTIAL, SOLUTION TO THE PROBLEM, IS ALREADY EMERGING AND I MUST SAY I FIND IT VERY INTERESTING. GROUPS SUCH AS THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS, CHAMBERS OF COMMERCE AND TRADE OR PROFESSIONAL ASSOCIATIONS ARE BEGINNING TO OFFER HEALTH CARE PLANS TO BUSINESSES WHICH ARE MEMBERS OF THEIR ORGANIZATIONS. UNDER THIS OPTION, SMALL BUSINESSES ARE NO LONGER TINY ENTITIES WITH SMALL RISK POOLS, BUT MEMBERS OF ORGANIZATIONS WITH MANY INDIVIDUALS AMONG WHOM THE RISK CAN BE SPREAD. IN OTHER WORDS, SUCH PLANS OFFER SMALL BUSINESS THE CHANCE TO BE ON A SIMILAR FOOTING AS BIG BUSINESS WHEN IT COMES TO OBTAINING AFFORDABLE HEALTH INSURANCE PLANS.

I BELIEVE THAT WE MUST PROCEED CAUTIOUSLY IF WE

ARE TO IMPLEMENT SWEEPING CHANGES WHICH WOULD MANDATE BENEFITS OR PROVIDE BROAD INCENTIVES THROUGH THE USE OF THE TAX CODE. PAST EXPERIENCE SEEMS TO SHOW THAT THE MORE WE REGULATE THE HEALTH CARE OF THIS NATION, THE MORE PROBLEMS WE TEND TO CREATE. AT THE SAME TIME, THIS IS A SERIOUS PROBLEM WHICH DESERVES THE CAREFUL CONSIDERATION OF CONGRESS.

TODAY'S HEARING WILL BE MOST IMPORTANT IN HELPING US DECIDE WHICH COURSE TO TAKE. I THANK THE WITNESSES FOR TAKING THE TIME TO TESTIFY THIS MORNING AND I LOOK FORWARD TO HEARING THEIR TESTIMONY.

STATEMENT BY SENATOR ALFONSE M. D'AMATO
BEFORE THE SMALL BUSINESS COMMITTEE
APRIL 23, 1987

MR. CHAIRMAN, I WANT TO WELCOME TO THE SMALL BUSINESS COMMITTEE THIS MORNING OUR DISTINGUISHED WITNESSES REPRESENTING A VARIETY OF INTERESTS IN THE SMALL BUSINESS COMMUNITY. I LOOK FORWARD TO YOUR COMMENTS REGARDING THE IMPACT OF HEALTH CARE LEGISLATION ON SMALL BUSINESS.

ONE OF THE MAJOR ISSUES FACING CONGRESS THIS SESSION IS THAT OF HEALTH CARE BENEFITS AND HEALTH INSURANCE COVERAGE. TODAY, THERE ARE APPROXIMATELY 37 MILLION UNINSURED INDIVIDUALS IN THE UNITED STATES. 54 PERCENT OF THESE PEOPLE ARE EMPLOYED BY SMALL BUSINESSES. WHILE SOME WORKERS IN SMALL BUSINESSES MAY BE COVERED UNDER A SPOUSE'S INSURANCE PLAN. MANY WHO DO NOT HAVE EVEN THIS COVERAGE. FOR INSTANCE, IN 1983, ONLY 39 PERCENT OF WORKERS IN FIRMS WITH FEWER THAN 25 EMPLOYEES WERE COVERED BY THEIR EMPLOYER'S HEALTH PLAN.

HOWEVER, WHILE COGNIZANT OF THE MILLIONS OF INDIVIDUALS WITHOUT EMPLOYER PROVIDED HEALTH BENEFITS AND INSURANCE, WE MUST ALSO BE AWARE OF THE IMPACT OF IMPOSING MANDATORY BENEFITS WILL HAVE ON SMALL BUSINESSES, AND ULTIMATELY ON

CONSUMERS. SUCH A BURDEN COULD VERY WELL PUT MANY SMALL COMPANIES OUT OF BUSINESS DUE TO THEIR INABILILITY TO COVER INCREASED LABOR COSTS. STATISTICS INDICATE THAT 20 PERCENT OF ALL NEW BUSINESSES FOLD WITHIN ONE YEAR AND MOST OF THOSE THAT SURVIVE DO NOT TURN A PROFIT FOR AT LEAST 18 MONTHS. INFLEXIBLE MANDATORY HEALTH BENEFITS COULD BE A CRIPPLING BURDEN TO A NASCENT ENTERPRISE IN THIS FRAGILE, START-UP PHASE. IMPOSITION OF SUCH BENEFITS COULD CAUSE THESE STATISTICS TO RISE DRAMATICALLY, MUCH TO THE DETRIMENT OF SMALL BUSINESS AND THE NATION'S ECONOMY.

I LOOK FORWARD TO HEARING TODAY'S TESTIMONY AND HOPE THAT THE VIEWS SHARED WILL HELP THE MEMBERS OF THIS COMMITTEE CRAFT LEGISLATION TO RESOLVE THIS DILEMMA.

THANK YOU, MR. CHAIRMAN.

QUESTIONS FOR FRANK SWAIN
FROM SENATOR ALFONSE D'AMATO

1. What alternatives exist for employers of small businesses who are without an employer-provided health insurance plan? How would you suggest that the small business community plan to cope with this problem?

2. If Congress were to pass legislation mandating businesses to provide health insurance to employees, should a limit be established on the size of companies falling under this mandatory law? What size do you view as reasonable?

U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

OFFICE OF CHIEF COUNSEL FOR ADVOCACY

June 3, 1987

Honorable Dale Bumpers
Honorable Lowell Weicker, Jr.
United States Senate
Committee on Small Business
428-A Senate Russell Office Building
Washington, D.C. 20510

Dear Senators Bumpers and Weicker:

The following answers are in response to questions submitted by Senator Bond and Senator D'Amato for the April 23 hearing on small business and health care.

CHARACTERISTICS OF SMALL EMPLOYERS WITH HEALTH COVERAGE

For competitive reasons, all employers are interested in providing health benefits to attract and retain employees. Health care is second only to vacations the most common fringe benefit. The kinds of small firms that offer health care coverage to workers tend to be all but the very small: over 90 percent of employers with over 25 employees offer coverage, compared to 78 percent of firms with 1-24 employees, or 46 percent of firms with fewer than 10 employees. Firms which lack insurance are mostly in retail trade, construction, and certain services. Approximately 70 percent of companies in other industries offer coverage. Small firms with plans experience higher and more stable profits. For example, small businesses that are likely to join an association or Chamber of Commerce are more likely to be able to afford to purchase health care. Moreover, relative to small firms without coverage, small firms with coverage, in general, have more stable workforces, i.e., lower turnover, fewer temporary, seasonal, or part-time workers.

SMALL BUSINESS EXEMPTIONS UNDER A MANDATE

As you know, the small business community remains overwhelmingly opposed to employer-mandated health coverage. Legislative proposals that I have seen would not lower the cost of health care to small firms, which is the principal problem faced by employers not presently offering this benefit. Insufficient profits was the number one reason cited by small employers who did not offer coverage. An exemption for small businesses of fewer than 25 employees would definitely help these firms who are least able to afford the cost of a mandate; however, these companies also employ about one-half of all uninsured workers. Therefore, proponents of a mandate are not likely to support any exemptions for small business.

VOLUNTARY ALTERNATIVES TO EXPAND COVERAGE IN SMALL FIRMS

My testimony included four policy recommendations for expanding coverage in small firms through voluntary incentives. These include extending the tax deduction from 25 to 100 percent for unincorporated business owners; encouraging development of a private catastrophic (low-cost) health plan through a limited Federal preemption of state mandates; examining the success and transferability of the 15 state programs currently underway that focus on assistance to uninsured small firms and low-income workers; and fostering education and promotion programs through the government and the private sector.

I would be happy to more fully discuss these options with you or your staff. Please do not hesitate to call me or Patricia Powers of my staff at 634-6115.

Sincerely,

Frank S Swain

Frank S. Swain
Chief Counsel for Advocacy

Senator **Bumpers**. Gentlemen, thank you both very much for being with us this morning.

Our next panel consists of Mr. Robert L. Shoptaw, executive vice president of Blue Cross and Blue Shield of Arkansas, Ms. Mary Nell Lehnhard, vice president of Blue Cross and Blue Shield Association, Washington, Mr. Michael Manley, second vice president, The Travelers Companies, Hartford, CT.

Ms. Lehnhard, Mr. Manley, Mr. Shoptaw, welcome to the Committee, we are very pleased to have you this morning. We will begin with Mr. Shoptaw.

Thank you all very much for coming. Mr. Shoptaw, please proceed.

STATEMENT OF ROBERT L. SHOPTAW, EXECUTIVE VICE PRESIDENT, ARKANSAS BLUE CROSS AND BLUE SHIELD

Mr. **Shoptaw**. Mr. Chairman and members of the Committee, I am Robert Shoptaw, and I am the executive vice president of Arkansas Blue Cross and Blue Shield. As a major health insurer, our programs cover over half a million Arkansans both in small business, in individual circumstances, and also the large employer market. Many of these policyholders of course, the small businesses, fall in categories that we typically identify with less than 100 employees. In fact, we cover some 3,000 small businesses in that particular category.

The issue of escalating health care costs represents a dark cloud which hangs not only over small businesses, but also is a systemic problem which adversely affects all segments of our economy. And certainly that has been alluded to here this morning.

As I will explain in a moment, small business does seem to be impacted even more adversely than most. As a good starting point, I think the symptoms of the problem should be examined and certainly Mr. Swain's comments this morning did an awfully good job in that regard.

In looking behind the statistics we believe there are a number of policy factors for the increasing size of the uninsured population. These factors include the current depressed economy in many small business oriented industries such as agriculture, forest products and light manufacturing.

Large corporations, Senator Bumpers as you suggest, who self-insure have a major cost advantage over small businesses who seek coverage through traditional, regulated insurance carriers. Large self-insured companies who operate under the Federal ERISA exemption are not subject to State mandated costs such as premium taxes or assessments for guaranty funds or high risk pools like small business must often support.

Cost shifting, particularly by hospitals is another major factor leading to the unaffordable insurance premiums for the small business entity. Two dynamics are at work here. First, Medicare and Medicaid have traditionally paid less than the going rate for the medical services they purchase on behalf of government sponsored patients. In Arkansas, for example, this differential approaches 25 percent. Providers of care compensate for these revenue shortfalls by artificially increasing the charges to either the private pay patient or the patient's insurance carrier.

A second component of the cost shifting problem is the recent entry of HMO's and negotiations by large employers in seeking price volume discounts from providers of care. Again, lost revenues are being made up by cost shifting to the remaining base of private patients. Many of these patients are obviously covered under small business sponsored insurance programs.

Finally, the fact is that many Americans, for whatever reason, have simply opted not to continue to actively participate in this country's system of private insurance protection. This is in light of the fact that some 4.2 million uninsured individuals have family incomes exceeding $40,000 annually.

To summarize these points, three distinct trends are emerging; self insurance by large employers, alternate delivery systems such as HMO's, and the absence of insurance coverage by an increasing number of Americans associated with small business concerns.

There is certainly nothing wrong with either self-insurance or alternate delivery systems. The problem is that neither of these approaches necessarily meets the needs of small business. A small business concern cannot afford to self-insure. To do so would subject the firm to undue risk of an occasional large claim that could bankrupt the enterprise and leave a very ill patient without health coverage. The HMO alternative presents two problems for small business. First, they are typically confined to only highly populated urban areas. And second, they are seldom less expensive than traditional health insurance coverage, although they do generally provide a wider range of benefits.

In our opinion, much of the problem of affordable health insurance coverage for small business is couched in a number of major unresolved public policy issues. These include:

The adverse impact of Medicare and Medicaid cost shifting to the private sector.

The continuing high cost of medical malpractice insurance which is passed along to the end consumer of medical services.

State level mandated benefits which unnecessarily drive up health insurance costs to those who must purchase fully insured coverage through a regulated insurance carrier.

The presence of antiquated statutes which inhibit competition. For example, only 20 States, according to a recent Rand Corporation study, have enacted preferred provider organization or PPO statutes.

Finally, the need to establish reasonable parameters for the introduction and extension of new health care related technology, some of which appears to be of marginal value relative to health outcomes.

These public policy issues should be addressed immediately and in an effective and balanced fashion.

On a parallel basis, the private sector should accept its share of responsibility in solving the problems we face. As an industry, we must treat small business fairly. This is particularly critical in areas such as establishing equitable risk pools around which community rating structures can be built. Most importantly as an industry, we must do what we claim to do best, and that is to innovate, to organize resources in the most efficient fashion and be willing to take our share of the reasonable risk in the process.

What we are taking about here today has a profound impact on a large number of Americans in three basic ways; their health, their money and their ability to earn a livelihood in a vocation of their choosing. All three of these are obviously quality of life issues. If effective action does not occur, the unsettling statistics that have been quoted here today are likely to multiply. In a worst case scenario, the continued out-migration to the ranks of the uninsured will accelerate. As the cost of new waves of uncompensated care is shifted to the private sector and insurance premiums rise accordingly, additional segments of the population will increasingly find prepaid health coverage unaffordable. Ultimately such a spiral could result in the collapse of private health insurance as we know it today.

We believe that the objective or readily accessible, quality health care at affordable cost to the vast majority of the citizens of this country remains within our reach. We also believe that a balanced approach between reasonable regulation and effective competition is the best vehicle to achieve these goals. A major disruption such as the scenario I have just described can and should be avoided.

Thank you very much, Mr. Chairman, for the opportunity to comment.

[The prepared statement of Mr. Shoptaw follows:]

TESTIMONY OF
ARKANSAS BLUE CROSS AND BLUE SHIELD
A MUTUAL INSURANCE COMPANY

COST AND AVAILABILITY OF HEALTH CARE BENEFITS FOR SMALL BUSINESS AND THEIR EMPLOYEES

BEFORE THE
SENATE COMMITTEE ON SMALL BUSINESS

PRESENTED BY:

ROBERT L. SHOPTAW
EXECUTIVE VICE PRESIDENT

APRIL 23, 1987

Mr. Chairman and members of the committee, I am Robert Shoptaw, Executive Vice President of Arkansas Blue Cross and Blue Shield. As a major health insurer, our programs cover over one-half million Arkansans under the age of 65. Many of these policyholders are owners or employees of small business concerns. More specifically, we provide prepaid health coverage to some 3,000 small business employers with less than 150 employees. This translates into 155,000 individual insureds.

The historical contribution of small business to this country's economic success is well chronicled. Today, it again appears that small business will be the vanguard of our economic future. This conclusion appears to be widely shared as we move into a new era based on information management, innovation, and a services industry orientation. Recent events in our economy tend to suggest that bigger is not necessarily better. In fact, in terms of creating new jobs, smaller is proving to be superior.

Background Information

The issue of escalating health insurance costs represents a dark cloud which hangs over most small businesses today. This is in large measure a systemic problem which adversely affects all segments of our economy. As I'll explain in a moment, small business is impacted even more adversely than most.

As with virtually any complex problem, neither the definition of the cause nor a viable solution are simple to construct. A convenient starting point, however, is to review the symptoms of the root problem. Based on recent reports published by the Robert Wood Johnson Foundation and the Employee-Benefit Research Institute, we now know that:

- One out of every six Americans lacks adequate health insurance coverage from either private or public sources.
- Of these 35 million uninsured Americans, one-third are children under the age of 18.
- Uninsured workers total 19 million with two out of three earning less than $20,000 per year.
- One-half of all uninsured workers are concentrated in two industries: retail trade and services.
- Approximately 16% of uninsured workers are self-employed.
- Surprisingly, of the 37% of the uninsured population with family incomes above $20,000, one-third or 12% of all uninsureds represent families with incomes of $40,000 and above.

Statement of the Problem

All of this tends to underscore two key facts in our view. First, there are approximately 12 million Americans with family incomes less than $10,000 per year that literally cannot afford to purchase adequate private sector health insurance coverage. The second point relates to the fact that a sizable number of people apparently elected to simply drop out of the system for whatever reason. This has occurred although they could certainly afford adequate coverage.

In looking behind these statistics, we believe there are a number of causative factors for the increasing size of the uninsured population starting with the current economy. In Arkansas, and generally in the southwest, our economy is heavily reliant upon small business concerns which are in a seriously depressed state. Much of the economic problems with oil, agriculture, forest products, and light manufacturing have fallen hardest on this region. In fact, the states of Arkansas, Oklahoma, Texas and Louisiana have a regional average of 23.4% uninsured population. This is the highest in the nation.

Another contributing factor to this problem is competition. In many respects, the recent emphasis on health care industry competition is both part of the problem (at least in the short run) as well as being part of the solution. Let me attempt to explain this dichotomy.

In today's largely international marketplace, small business must compete with foreign companies on much the same basis as do their larger domestic counterparts. Here small business becomes sorely disadvantaged. Reasonable profit margins are seriously eroded by differentials in health care costs that are factored into the goods and services they produce.

For example, health care costs per capita in the U. S. are three times as great as in Japan and generally double health care expenditures in Western Europe. Yet, the results of these higher cost outlays do not provide better health outcomes as measured in terms of standard mortality and morbidity statistics.

We believe that many small businesses have such narrow margins that electing not to sponsor health insurance programs for their employees is the difference between staying in business or closing the doors.

From a different perspective, small business must compete effectively with large domestic companies if they are to survive. Once again, small business is on less than a level playing field.

Most larger corporations now self-insure their employee health benefit programs under the provisions of the Employee Retirement Income Security Act of 1974, better known as ERISA. As a result, larger employers are exempt from state level regulation. Since insurance carriers from whom small businesses must seek health insurance coverage are subject to state statutes and regulations, a disparity in health insurance costs ensues. For example, small business must pay indirectly through their insurance the additional expense of state premium or franchise taxes, the cost of state mandated coverages, and in some cases participate in guaranty or high risk pool assessments that do not apply to large self-insured employers.

The third impact of competition on small business is cost shifting. Historically, both Medicare and Medicaid have paid less for their sponsored patients than the charges for comparable services to private patients. The result has been a shortfall in Medicare and Medicaid reimbursement which has been shifted in the form of higher charges to private patients or their insurance carriers. Today, with the advent of alternate delivery systems like HMO's and direct negotiations by large employers for price/volume discounts from health care providers, additional costs are artificially being shifted to the remaining base of private patients. Many of these patients are covered under small business insurance programs.

To summarize this point, three distinct trends are emerging -- self insurance by large employers, alternate delivery systems such as HMO's, and the absence of insurance coverage by an increasing number of Americans associated with small business concerns.

There is certainly nothing wrong with either self-insurance or alternative delivery systems. The problem is that neither of these approaches typically meets the needs of small businesses. A small business concern cannot afford to self-insure. To do so would subject the firm to the undue risk of an occasional large claim that could bankrupt the enterprise and leave a very ill patient without health benefits. The HMO alternative presents two problems for small business. First, they are typically confined to only highly populated urban areas. Secondly, they seldom are less expensive than traditional health insurance although they do generally provide a wider range of benefits.

In our opinion, much of the problem of affordable health insurance coverage for small business is couched in a number of major unresolved public policy issues. These include:

- The adverse impact of Medicare and Medicaid cost shifting to the private sector.

- The continuing high costs of medical malpractice insurance which is passed along to the end consumer of medical services.

- State level mandated benefits which unnecessarily drive up health insurance costs to those who must purchase fully insured coverage through a regulated insurance carrier.

- The presence of antiquated statutes which inhibit competition. For example, only 20 states, according to a recent Rand Corporation study, have enacted preferred provider organization or PPO statutes.

- Establishing reasonable parameters for the introduction and extension of new health care related technology.

Private Sector Response

Within the context of the circumstances I've just described, we believe that the private insurance industry has responded in a positive way to many of the needs of small business by:

- Encouraging redesign of health insurance programs away from first dollar coverage which invites patient initiated over-utilization.
- Sponsorship of HMO's and other forms of alternate delivery systems where the legal framework exists for such programs.
- Introduction of managed care programs which rely upon hospital admission certification, second opinion surgery, and outpatient surgery programs to reduce cost and preserve traditional quality of care.
- Development of comprehensive health data and reporting systems which can be used to assess utilization trends and promote quality of care through organized peer review.

The dilemma as we sit here today revolves around the fact that all these mechanisms are largely in place, yet the core problem not only persists but is growing at an accelerating rate. Obviously, additional action is needed.

Conclusions Reached

Neither private nor public sector remedial action can unilaterally solve this series of complex and interrelated problems. If ever there was an opportunity for coordinated action, this appears to be it. In terms of staging, we believe the first steps should be initiated by the public sector in the following areas:

- **First, state and federal governments should accept blanket responsibility for the structural level of uncompensated care in this country (principally for households with incomes of less than $10,000 annually). Medicaid appears to be the appropriate vehicle. The gap is wide. Today, less than half of the families below the poverty level qualify for Medicaid health coverage. In terms of funding, the Medicaid approach is at least as fair as our system of taxes since these funds come from general revenues.**

- A second key step would be to halt the accelerated rate of cost shifting to private patients by Medicare. This problem is especially evident in the new DRG based hospital reimbursement program. To take this action would not only make health insurance more affordable for the under age 65 population, it would be a positive step towards compliance with the spirit as well as the letter of the social contract this nation has extended to its elderly population.

- Small business or third parties representing their interests should be extended the same latitude and flexibility currently enjoyed by large corporations. This flexibility includes being free of costly state mandated benefits of marginal value and anti-competitive statutes which prohibit selective provider contracting and price/volume discounts from being negotiated.

- Mandated insurance coverage (not to be confused with mandated benefits which are a major part of the health cost problem) should be considered. There is already a precedent for such action in areas such as mandatory automobile insurance coverage. As important as individual freedoms are, there are situations where the public good must be given top priority. This may be one of these situations. On this point, I would like to enter a disclaimer. Mandated insurance coverage for small business employees only makes sense if it is affordable. To be affordable, it must be bare bones in its scope. For example, our typical monthly family rate for a comprehensive policy is $170. If only acute care M.D. and hospital services are covered, the rate could be reduced by as much as 25-30%. Even with a overall package, the expense of comprehensive mandated insurance coverage is out of reach of most small businesses, we have amplified rather than solved the problem.

o The issues of medical malpractice insurance costs and the rapid expansion of new, costly technology (some of which appears to be of marginal value relative to health outcomes) should be debated and then dealt with in a swift and effective manner.

On a parallel basis, the private sector should accept its share of the responsibility in solving the systemic problems we face. As an industry, we must treat small business fairly. This is particularly critical in areas such as establishing equitable risk pools around which community rating structures can be built. Small businesses should not be subjected to artificially high premiums as compared to actual claims utilization simply because they do not have a wide range of available options like large companies enjoy.

Most importantly, as an industry we must do what we claim to do best -- that is to innovate, organize resources in the most efficient fashion, and be willing to take our share of reasonable risk in the process.

What we're talking about here today has a profound impact on a large number of Americans in three basic areas -- their health, their money, and their ability to earn a livelihood in the vocation of their choosing. All three of these are obviously quality of life issues. If effective action does not occur, the unsettling statistics that have been quoted here today will likely multiply. In a worse case scenario, the continued outmigration to the ranks of the uninsured will accelerate. As the cost for new waves of uncompensated care is shifted to the private sector and insurance premiums rise accordingly, additional segments of the population will increasingly find prepaid health coverage unaffordable. Ultimately, such a spiral could result in the collapse of private health insurance as we know it today.

We believe the objective of readily accessible, quality health care at an affordable cost to the vast majority of the citizens of this country remains within our reach. We also believe that a balanced approach between reasonable regulation and effective competition is the best vehicle to achieve these goals. A major disruption such as the scenario I have just described can and should be avoided.

Thank you.

Senator BUMPERS. Thank you, Mr. Shoptaw. Ms. Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Mr. Chairman, Senator Weicker, I am pleased to be here with Mr. Shoptaw.

Blue Cross and Blue Shield Plans have a longstanding commitment to providing health insurance to small groups. Collectively our Plans cover about 13 million subscribers who are in small groups.

In reviewing this extremely important public policy issue today, we believe it is important to note that the cost of the health care benefits package for a small group tends to be higher on a per person basis than for larger groups. Both the benefit costs and the administrative costs, the two components of an employer's premium, will tend to increase as the group size decreases.

With respect to the benefits part of the premium, the most fundamental factor resulting in higher cost for a smaller group is the very high turnover rate. The number of employees within the group will tend to fluctuate and the groups themselves, as complete entities, will move in and out of coverage.

The employees who leave the small groups tend to be the younger, healthier individuals. The ones who stay with the group tend to be older and often less healthy individuals who do not want to risk losing health benefits for themselves and for dependents.

In addition, the movement of the entire group into coverage is often the result of the employer deciding to purchase insurance because there is an immediate or predicted need for health care by the employer, a family member, or an employee. Conversely, dropping the coverage may be triggered by that need ceasing, particularly where there is a very low profit margin.

All of this simply means that the small group market, much more than the large group market, tends to be made up of individuals who are actively using health care services, just exactly what you have heard today. The consequent higher benefit payments result in higher premiums for that employer.

This fluctuation in the small group market also has an effect on the administrative costs. Frequently groups leave coverage before insurers can recoup their costs of enrolling the group. Those costs must then be allocated to all other existing groups covered.

In addition, smaller groups will tend to have higher administrative costs on a per person basis because many of these costs are fixed overhead costs that do not vary significantly by group size.

While many of the factors that make health insurance more costly for small groups are beyond anyone's control, we believe that there are some immediate actions that the Government could take to assist small employers and their workers. Importantly we believe that small businesses should be relieved of the cost of state mandated benefits. To date, states have enacted well over 600 laws that require insured health benefits plans to cover specific services. Not only do these mandates result in a higher cost for employers, but they also prevent the employer and the employees from selecting the best set of benefits for that particular group.

Another action would be to increase the tax incentives for owners of unincorporated businesses to provide health insurance benefits.

I would also note, however, that although these actions have the potential to reduce the cost of health benefits, they probably would not help a relatively large number of the working uninsured. Any meaningful effort to make health benefits more available to small businesses will require probably some type of governmental support. We know that some in Congress are considering requiring all employers to offer health insurance benefits to their workers and while we are still reviewing this issue, it is clear as you have heard today, the potential serious economic repercussions for small business cannot be overlooked in this debate.

We also recognize that the private sector has a responsibility to make health benefits as affordable as possible for small businesses. The Blue Cross and Blue Shield Association has initiated a thorough review of our small group business and we hope to learn how we can better respond to the needs of small employers.

We would be pleased to share our conclusions when they are available and we look forward to working with you as you proceed on this important issue.

[The prepared statement of Ms. Lehnhard follows:]

TESTIMONY OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

COST AND AVAILABILITY OF HEALTH CARE BENEFITS FOR SMALL BUSINESS AND THEIR EMPLOYEES

BEFORE THE
SENATE COMMITTEE ON SMALL BUSINESS

PRESENTED BY:

MARY NELL LEHNHARD
VICE PRESIDENT

APRIL 23, 1987

Mr. Chairman, I am Mary Nell Lehnhard Vice President of the Blue Cross and Blue Shield Association. The Association is the national coordinating organization for the nation's 77 Blue Cross and Blue Shield Plans. We are especially pleased to be here today with Robert L. Shoptaw, Executive Vice President of Blue Cross and Blue Shield of Arkansas.

Blue Cross and Blue Shield Plans have a longstanding commitment to providing protection against the cost of health care to the small group market. Collectively, Blue Cross and Blue Shield Plans cover about 6 million subscribers in groups of 100 or less. Every Plan is active in this market with the percentage of small group business ranging from about 10 percent to 60 percent, depending on the nature of business in the state. Importantly, Blue Cross and Blue Shield Plans remain in this volatile market regardless of economic downturns that frequently cause other insurers to reconsider their participation.

Despite the significant number of small business employees covered by our system, we know that a very large number of similarly situated workers have no protection against the cost of needed health care. We share your concern about this disturbing situation and commend your leadership in opening a thorough examination of the issue.

In our statement today, we would like to offer some brief observations about the small group market, including why this segment of our business differs from moderate and large-sized groups, and what factors may influence a small employer's decision to offer health benefits to his or her employees.

As you examine possible government actions that could increase the level of coverage among those who work in small businesses, we would suggest that the most fundamental problem to be addressed is the affordability of health benefits for small employers and their employees. Coverage is available, but we know that the majority of the working uninsured are relatively low wage earners and that in many cases their employers are businesses with a low profit margin.

It is also important to note, in examining this important public policy issue, that the cost of a health benefits package for members of small groups tends to be higher on a per person basis than for larger groups for that same package. Both benefit costs and administrative costs, the two components of an employer's premium, increase as the size of the group decreases. The reasons for this cost differential are largely beyond the control of the employer or the insurer.

With respect to benefits payments, the most fundamental factor resulting in higher costs for smaller groups is the very high turnover. The number of employees in an insured group will tend to fluctuate and groups, as entities, will move in and out of coverage. It is not uncommon to find that one-third of small groups enrolled with an insurer leave each year.

This characteristic fluctuation in the number of employees covered and in the small employers enrolled, and more specifically, the reason for the movement, creates what insurers call adverse selection. Employees who leave small groups tend to be younger, healthier individuals. The ones who stay in the small group are often older and less healthy employees who are unwilling to risk losing health benefits for themselves and their dependents.

In addition, the movement of the entire group into coverage is often the result of the employer deciding to purchase insurance because there is an immediate or predicted need for health care services by the employer, a family member or an employee. Conversely, dropping coverage may be triggered by that need ceasing, particularly if the group is faced with a choice between adequate wages and health benefits.

This adverse selection means that the small group market, much more than the large group market, tends to be made up of individuals who are actively using health care services. The consequent higher benefit payments result in higher premiums for the employer. The cycle of adverse selection continues as the resulting higher premium triggers, once again, the younger and healthier groups leaving for less comprehensive coverage and lower rates.

The fluctuation in the small group market also has an effect on the health insurers' administrative costs. Frequently groups leave coverage before insurers can fully recoup the costs of enrolling the group. Those unrecovered costs must then be allocated to all other groups enrolled. A significant cost attributable to small groups also results from the absence of a benefit administrator normally found in larger groups. This means that the insurer must assume that role, following up on enrollments and disenrollments, and answering benefit questions. Finally, smaller groups will tend to have higher administrative costs on a per person basis than larger groups because many of the overhead costs are fixed costs and do not vary significantly by group size, for example, accounting, maintenance of enrollment, setting in place a billing procedure.

The problems in the small group market are well known and there is considerable activity in the private sector to address them. Although the practice is by no means new, Blue Cross and Blue Shield Plans community rate their small group accounts. This means that we aggregate these smaller accounts into one rating pool to spread the costs of their benefits over the largest possible number of insureds thus producing the most affordable premium. However, even with community rating, the high degree of adverse selection present in the small group market makes coverage for the entire pool more expensive than for similar coverage provided by a larger, more stable employer.

In another approach to creating an essentially community rated pool, small employers have come together to form larger groups or associations to purchase health insurance and other benefits. These associations of small businesses purchase insurance on behalf of their members thus providing the advantage of a substantially larger pool and ideally more affordable rates. Other small businesses purchase coverage through existing groups such as local Chambers of Commerce or other types of business coalitions. New entities such as Multiple Employer Trusts or Multiple Employee Welfare Arrangements, also are used to purchase coverage for small businesses. In all of these arrangements, not only is the insured group size larger, but there is also some type of umbrella administrative structure in place.

Blue Cross and Blue Shield Plans offer coverage through these types of associations. Over a third of our Plans report a significant market in Multiple Employer Trusts and associations. We support these efforts and hope for their success. However, our experience tells us that because the larger group is still made up of volatile small businesses, these programs also will face substantial turnover -- and resulting higher costs.

As noted earlier, the basic causes for higher costs of providing health benefits to the small group market are for the most part beyond anyone's control. It would be wrong to conclude, however, that nothing can be done to make benefits more affordable for small groups. We would suggest that there are some immediate actions that the government could take to assist small employers and their workers.

First, we believe that small businesses should be relieved of the costs of state mandated benefits. To date, states have enacted well over 600 laws that require insured health benefit plans to provide certain services. The Blue Cross and Blue Shield Association has supported government action to exempt all employer-provided health from these mandates. Not only do the mandates frequently result in higher costs for employers, but they also prevent employers and employees from selecting the set of health benefits most appropriate to their own specific needs. Importantly the Employee Retirement

Income Security Act, ERISA, has been interpreted to exempt companies who self-fund their health benefits, that is, pay their health expenses out of current operating funds, from these mandates. While we would like to see all employers enjoy this ability to determine their own benefit package, we believe that these mandates place a disproportionately higher cost burden on small employers.

A second consideration should be the tax treatment of health insurance premium expense for unincorporated small businesses. While we recognize that a 25 percent deduction for premium expense for these small firms was allowed under the Tax Reform Act of 1986, this may not be sufficient to encourage more coverage. Additional tax incentives may be possible and should be discussed.

The suggestions noted above have the potential of reducing the cost to small businesses of providing health benefits. However, their overall effect as we see it would be to help a relatively small number of individuals gain access to health insurance. Consequently, we also recommend that government examine its responsibility to the vast majority of workers in small businesses whose incomes are so low as to make any contribution to the costs of health benefits extremely difficult. Fully 75 percent of the working uninsured had family incomes of less than $10,000 in 1985, not that far above the poverty level in this country. The private sector cannot create an insurance program for these individuals. Any meaningful effort to make health benefits available to them will require direct government support.

Undoubtedly, there will be a number of other solutions discussed as your review proceeds, but we would like to stress that the problems of availability and affordability of insurance to small businesses vary tremendously across the country. Certainly these problems are worthy of national attention, but we would recommend that national initiatives to encourage and support local solutions be given the strongest consideration. We know that some in Congress are considering requiring all employers to offer health benefits to their workers. While we are still reviewing this issue, it is clear that the potential of serious economic repercussions for small business in some parts of our country cannot be overlooked in the debate.

The private sector also has work to do on the issue of affordability of insurance to small business. The Blue Cross and Blue Shield Association has begun a review of our small group business and we hope to learn how we can better respond to the needs of small business. We would be pleased to share our conclusions when they are available, and we look forward to working with you as your proceed.

Senator **Bumpers**. Thank you very much. Mr. Manley.

Senator **Weicker**. Mr. Chairman, I would like to welcome Mr. Manley from one of our——

Senator **Bumpers**. One of those big insurance buildings up in Hartford.

Senator **Weicker**. One of those very important, very successful insurance operations in Hartford. But of special interest to the Chairman—and I just learned about this 2 days ago when I picked up my Sunday *Hartford Courant*—was that one of the endeavors in which The Travelers Insurance Company is deeply involved—and the Courant had a whole section just on this activity—is catfish farming. [Laughter.]

So you might keep in mind since I do not know what your feelings of hostility were to this witness—that they are big in catfish. [Laughter.]

I know the Chairman's interest in this matter since the day he walked in the United States Senate—there used to be $500,000 research money for catfish farming—and I just wanted to apprise him of this additional interest of the company represented by Mr. Manley.

Senator **Bumpers**. I am really titillated by all this. [Laughter.]

Also pray for my good health because I have got two big life insurance policies with The Travelers. [Laughter.]

STATEMENT OF MICHAEL J. MANLEY, THE TRAVELERS COMPANIES, HARTFORD, CT

Mr. **Manley**. Thank you, Mr. Chairman, it is nice to know we have several different connections, and thank you, Senator Weicker.

I am Mike Manley from Travelers and we are pleased to be here this morning to talk about small business and health care. As a national employer, and a national insurer, we are very concerned about the problems of availability and affordability of health insurance for all Americans. And we welcome the opportunity to share our experience in this market with you.

We have submitted a written statement for the record and, in the interest of brevity here this morning, I would like to just summarize a few key points since we have already heard a great deal.

The business area that I manage for The Travelers is responsible for our employee benefits business—for customers with 2 to 49 employees and it is a relatively big business for us. We have over 50,000 of those customers and they bring in about 20 percent of our employee benefits revenue. But more important, they represent about 95 percent of all of the customers with whom we do business in the Employee Benefits Department. So we spend a lot of time on it and it is a very important market to us.

It is also a very important market, I think we should note, to the independent agents who represent The Travelers and other companies around the country. Small businessmen, by and large, do not have the time to be experts about insurance and they rely very heavily on the advice of insurance agents. These agents perform a very important function in that market and provide a real value to small business owners, in our experience.

Based on what I have seen, I think small businesses are willing to pay for that service, but despite the fact that they are willing to pay for the services of agents, and are willing to pay for high quality services from carriers, this is indeed a price sensitive market. And, if anything, is becoming more so, driven largely by the rising cost of medical care.

It is also, I think, exacerbated in its price sensitivity by the very strong competition we see in this market. There are not very many barriers to virtually anybody getting in and providing employee benefits to small businesses. We see third party administrators, we see small insurance carriers as well as national carriers, we see multiple employer trusts, we see PPO's, HMO's. There are virtually thousands and thousands of competitors in this market and I think it is true—it is certainly true from our perspective—that if the customer wants to look around at any point in time, he can almost always find somebody who has a lower price than his existing carrier. I would say from our perspective, therefore, that there is not an access problem that we are talking about here. Small business can indeed virtually always get access to employee benefits and there is not a question of quality of coverage because we and many of our competitors provide just as broad coverage to this market as any large employer can buy.

But certainly there is a cost problem. As you have heard, administrative costs in this market are higher than they are for larger employers. In our business I think those costs tend to run about 20 percent higher than the cost of administration for large companies. And one of the issues there, as you have heard, is turnover among these groups. We have our small business customers submit applications to us for each of their new employees and we see about 25 to 30 percent turnover in that entire group of business. We cover about 350,000 employees and we see on average 9,000 or 10,000 new employees coming into that business a month and that means probably almost as many going out. So that is a problem.

It is also true that State mandated benefits raise the costs here. They raise administrative costs that we build into our product pricing, and they can raise the cost of claims in these products by as much as 10 percent based on what we see. So there is a cost problem there.

But I think it is important to remember that the significant cost problem for small business, as it is for large business and Government and everybody else who provides employee benefits is not administration; it is the cost of medical care itself, and the rising cost of medical care over the last few years, not only because of price but because of utilization of care.

And we think, therefore, that really the best long-term solution for making health insurance affordable to small businesses are those things we can do to help control the cost of medical care itself, the underlying cost of medical care. I think, if we look at our industry, we see a great deal of innovation that has been going on in the last few years directed at doing precisely that. We have seen innovative plan designs, the use of deductibles to provide incentives for appropriate use of medical care, things like pre-hospital review of inpatient care, second and third opinion programs; more recently, preferred provider programs, where you get groups of physicians and hospitals who try to help control utilization and the price of care—and HMO's. A great deal of innovation going on in the private industry is directed simply at controlling medical care costs and the basis of it really is competition. Employers are looking for lower prices and I think industry has been doing a great deal to try and respond to it.

One of the areas, though, that we think has been largely neglected, at least for small business, is the idea of health promotion as a cost-decreasing factor. Large businesses have been getting into health promotion more over recent years, but small business has been largely unserved and largely because it is difficult to—there are a lot of small units and it is difficult to—get to them with health promotion programs. They need programs that are simple to use, that are transportable, that are inexpensive.

We have been experimenting over the last year with building into some of our small business programs, a program we call "Taking Care." It is a communication-based health promotion program developed by our subsidiary, the Center for Corporate Health Promotion. And it is really based on the idea that health promotion and medical self care are not things that a professional does to you, but something that you do for yourself. And giving information that they can use will make people better participants in their own health and medical care. We have limited experience with that program in small business, but we have got a fair amount of experience with large groups, and based on our experience so far, people do use that kind of information if you give it to them, and it does change the way they behave in respect to health and medical care. We think it is an area that really needs to be pushed very strongly.

I guess to summarize very quickly then, when we look at that market we see very active competition. We think employers can get access to high quality benefits, they are getting the advantage of competition in controlling costs. Medical care costs are the significant problem here and we think, in the long run, that what we ought to be doing is looking for ways first of all to support private efforts to control medical care costs, and look at ways for relieving extra burdens on small employers in obtaining benefits, like the problem of State mandated benefits, like the problem of providing incentives through taxes for being able to deduct the cost of employee benefits.

Thank you.

[The prepared statement of Mr. Manley follows:]

STATEMENT

OF

THE TRAVELERS COMPANIES

BEFORE THE

SENATE COMMITTEE ON SMALL BUSINESS

ON

"SMALL BUSINESS AND HEALTH CARE"

APRIL 23, 1987
WASHINGTON, D.C.

Presented by
Michael J. Manley
The Travelers Companies

Good morning, Mr Chairman and Members of the Senate Committee on Small Business. I am Michael J. Manley, Second Vice President for The Travelers Companies. The Travelers is pleased to be here at your hearing to discuss small business and health care. As a national employer and insurer, we are greatly concerned about the problems of access and availability of health insurance for all Americans. We welcome the opportunity to share with you our experience in providing health coverage for small business.

The Travelers Corporation is one of the world's largest multi-line insurance, financial, and health-services institutions, with $46.3 billion in assets. Through its affiliated companies, it provides a wide range of products and services in the employee benefits field--including group life and health insurance, group dental insurance, disability insurance, and health promotion. Our goal is to help employers--large and small--obtain the maximum return for each benefit dollar spent.

Today, I will describe the small business market targeted and served by The Travelers. I will also address general issues of availability and affordability, barriers to health insurance, and options for controlling costs.

The Travelers Small Business Market

Small business--in particular those firms with fewer than 50 employees--is big business to The Travelers. We have 51,500 employee benefit customers, generating between $900 million and $1 billion in annual premiums for The Travelers--approximately 20 percent of our Employee Benefits Department's annual revenues. These firms represent over 95 percent of all the organizations with whom we do business. My unit handles firms with two to fifty employees and provides small businesses with a full range of health-insurance products and services.

Our small business market is a national one--we sell employee benefits to small businesses in all fifty states. Since taking over this unit in November, my staff and I have traveled around the country meeting with more than 80 insurance agents to observe this market firsthand. Our goal is to provide a comprehensive and stable source of benefit plans for our small business customers. Clearly small businesses need and demand high quality employee benefits just as large businesses do--especially if they must compete with larger companies for the same pool of workers.

Of the 35,000 small firms which my business unit serves, roughly 16,500 of them have fewer than ten employees; and 18,500 have between ten and forty-nine employees. The average number of employees is ten. As you know, many small businesses obtain health coverage through membership in trade associations. At The Travelers, we insure 16,500 small businesses through ninety different association plans--with firms averaging about twenty employees each.

The Role of the Independent Insurance Agent

Small business is also important to the thousands of independent insurance agents who represent The Travelers and who are themselves small business persons. In selling and servicing employee benefits for these small business customers, Travelers deals with approximately 22,000 independent insurance agents throughout the United States. Because the agent serves as a valuable resource, small employer loyalties tend to be with their own agent--not with the insurance carrier. You should know that the agent can play a significant role in directing the purchase of employee benefits by small businesses. Agents who sell employee benefits often provide the same small business owner with their property-casualty coverages or with business life insurance.

Typically, small business owners and managers have little time to become experts on insurance and are largely guided in their decision making by an agent in whom they have developed confidence. Based on our experience, small employers are willing to pay for the services of a high quality agent, and on that agent's recommendation are also willing to pay more for reliable claim and administrative services.

Competition and Availability

The small business market is price sensitive. As you are all too well aware, cost is a major factor in any employer's choice of a new benefits program or in a decision to "shop" the benefit plan at renewal time. While small firms may experience some disruption in switching carriers, it is not nearly as significant a problem as that faced by very large employers.

Nevertheless, rising medical care inflation has made price an increasingly important factor in the market. When health care costs were relatively stable in the late sixties and early seventies, The Travelers experienced annual small business turnover rates of fifteen to twenty percent. In recent years, however, with annual health care prices dramatically increasing, the rate of small business customer turnover has been as high as thirty percent.

Small business price sensitivity appears to be heightened by the highly competitive nature of the market. While only a limited number of insurance carriers have the resources and skills to meet the demands of very large customers, there are few barriers to entering the small business market. Literally thousands compete in this market, including all sizes of insurance carriers--from small local companies to national ones like The Travelers, third party administrators, multiple employer trusts (METs), preferred provider organizations (PPO's), and health maintenance organizations (HMO's). Thus customers without abnormal risk who shop around, can almost always find a better price than what they are currently paying.

How does The Travelers compete in this market? First, we tend to be extremely liberal in our underwriting requirements for small firms. We do not exclude any group of industries from coverage. For the smallest groups--those with fewer than ten employees, we do not underwrite health insurance for employees or dependents. Nevertheless because underwriting is a common practice of our competitors, we may soon be forced to begin underwriting ourselves.

Next, we also offer an unusually broad range of benefits options for the small business market. We offer so-called "packaged" benefit programs as a way of limiting the options and controlling administrative costs. However, within our "package" program, there are over twenty different types of benefit programs that employers can choose, including different varieties of benefit structure: basic plus major medical programs, comprehensive medical expense programs, special cost containment programs, and preferred provider arrangements. Since The Travelers markets these benefit packages throughout the United States, we attempt to include enough options within our packages to meet the needs of customers in all geographic regions.

We also provide relatively liberal benefits through these "package" programs. Indeed, small business can buy health benefit coverages from The Travelers that are just as liberal in terms of coverage as that purchased by most large companies. For instance, it is possible for a small employer to purchase a benefit package that pays the full costs of hospital care with no maximum limit, the reasonable charges for surgery and other in-hospital physician's care, the full reasonable charges for laboratory and x-ray examinations, and, after a $100 deductible, 80 percent of any other necessary charges with an overall limit on any individual's out-of-pocket expense of $500 in a calendar year. There are few large carriers in the United States that offer a benefits plan as liberal as this one.

We should note, however, that in recent years the trend has been away from benefit programs that offer first dollar coverage for medical costs. Currently, the most popular plans are those that impose a deductible before any benefits are paid and include some co-payment by the employee. As an example, one of the more popular plans for both large and small employers incorporates a $100 calendar year deductible that must be satisfied before the plan pays any benefits; and then, the plan pays 80 percent of all necessary medical care until the individual has paid $1,000 in a calendar year. At that point, the plan pays 100 percent of further expenses for the year. In other words, these plans routinely offer catastrophic coverage. In light of the current Congressional debate concerning catastrophic health coverage, I am sure that you are familiar with the need for such important coverage.

Because the small business market is highly competitive, however, a great many other carriers offer similar types of benefit programs. Therefore, with only limited exceptions, The Travelers believes that high quality and broad coverage of health care _is_ widely available today to small firms.

State Mandated Benefits and Costs

The Travelers complies with mandated benefits in each of the fifty states. For a number of reasons, these mandates present significant administrative problems for our business. First, these state requirements tend to be continually changing. Second, they typically apply to all outstanding contracts on renewal as well as new business. Besides the resulting administrative problems, these mandated coverages can add 4 percent additional claims cost onto the basic cost of our programs. That 4 percent, in fact, is understated since The Travelers has incorporated many of the more commonly mandated benefits into our basic program (e.g., specific benefits for mental and nervous disorders, alcohol and drug treatment, and specific provider such as psychiatric social workers and chiropractors).

Because mandated benefits present serious administrative burdens of complying with different and changing laws in fifty jurisdictions, many of Travelers competitors in the small business market set up trusts in states with relatively few mandated benefits. By doing this, they are able to use that state's laws to govern their contracts in all other states.

Travelers longstanding opposition to state mandated benfits laws has been well documented. Along with Metropolitan Life, we argued before the Supreme Court that federal law preempts state mandated benefits. In a 1985 decision, however, the justices ruled against us. They found that a state law which compels insurance companies to provide maximum level of mental health care benefits in group health insurance policies offered to employee benefit plans is not preempted by federal law. The Court affirmed that a Massachusetts mandated benefit law is not preempted by either the Employee Retirement Income Security Act or the Taft-Hartley Act.

We strongly urge that the Congress consider enacting an ERISA preemption of state mandated benefit laws for insured benefit plans purchased by employers. Such an ERISA preemption would be a major first step to lowering the costs of health insurance for small businesses.

Costs and Affordability

A key health insurance barrier for many small businesses is the cost of employee health benefits. There are significant cost variations in benefit plans across the United States, primarily linked to the price and utilization of medical care in those regions. It is also true that administrative costs for smaller businesses is a higher percentage of the overall premium than that for very large customers. Many of the expenses associated with underwriting and maintaining accounts are relatively fixed expenses, and as the size of the group and the premium decreases those fixed expenses become a higher percentage of the total premium. At The Travelers, our costs for small group cases are approximately 20 percent higher than for our large customers.

Nevertheless, The Travelers contends that the truly significant problem for small business employers is not administrative costs. In common with large employers and in common with the government, the most significant problem is the cost of medical care itself--driven not only by price inflation but by steadily increasing utilization.

Because the underlying problem for small business is the actual cost of medical care itself, the most effective ways of helping small business afford health care are those programs that will help to control the actual costs of care. The innovations we are seeing in plan design and programs to manage health care, the development of preferred provider arrangements and health maintenance organizations, and the growth of health promotion, are perhaps the best solutions for making health insurance affordable for small employers.

1. Plan design - Travelers and our competitors are experimenting with plan designs and specialized services that are designed to have an impact on the utilization of medical care. For example, there is a distinct movement toward the use of higher deductibles and more deductibles to discourage inappropriate use of care by employees and their families. While a $100 per calendar year deductible is the most popular amount, we now see many more plans using a $200 deductible, or one as high as $500.

There is also more frequent use of deductibles for each admission to a hospital, again designed to discourage unnecessary impatient care. Benefit programs may also impose so-called penalty deductibles if employees fail to seek second surgical opinions for certain kinds of surgery or if they fail to use hospital pre-certification programs. By making the employee pay more of the bill today, these deductibles are not being used so much to save money for the plan, as they are trying to discourage inappropriate behavior by imposing penalties for it.

A popular service now being used by Travelers is pre-certification of inpatient hospital care. Physician recommendations for inpatient care are reviewed by a third party against guidelines for standards of practice. Under some programs, employees are not paid benefits for hospital care that do not receive prior approval. Many plans are also requiring mandatory second surgical opinions for certain specified types of surgery. In instances where people do not use the review organizations or do not obtain the required second opinions, the level of benefits may be scaled back to perhaps as much as 50 percent of charges rather than 80 percent

2. Preferred provider arrangements - Travelers and other companies are also experimenting with preferred provider arrangements. Such arrangements, commonly known as PPO's, use networks of physicians and hospitals which cooperate in controlling utilization and costs in return for an increased flow of patients. Firms with as few as two employees can elect coverage in a Travelers PPO.

We have found this alternative to be even more cost effective than managed care, and estimate that a PPO can help a small employer reduce health costs by as much as 15 to 20 percent. To the extent that various state laws may present barriers to the establishment of PPO's, we suggest that you review the situation in your home state.

3. Medical underwriting - In order to control costs, many competitors are becoming more selective in the business they will write. Carriers are more stringent in their medical underwriting for both employees and dependents--especially in firms with fewer than ten employees. These same carriers are also underwriting the characteristics of the employer, in terms of how many years they have been in business, whether they have switched carriers

frequently, whether they have high employee turnover, etc. And in contrast to Travelers practice, many of our competitors have established lists of industries which they will not consider for employee benefit coverage.

Clearly, the trend of increased innovation in programs to control medical utilization and costs is a positive one for customers. As these programs mature and become more effective, overall health care costs will be better controlled, and that should translate into more favorable prices for our small business customers.

Quite frankly, however, the increasing selectivity of a growing number of carriers makes it more difficult for many small customers to obtain coverage. Or, if these firms have employees with serious medical problems, it will be difficult to switch to more favorable contracts or prices since a new carrier will not pick up existing medical conditions. Thus we find that this particular trend is a barrier for small firms in obtaining adequate benefits coverage.

4. Health promotion - A critically but generally neglected tool, however, is the more aggressive use of health promotion by small employers. At The Travelers, we are convinced that a great deal can be done in this respect. Until recently, it has been relatively difficult to service small businesses with health promotion programs, and therefore these firms have been underserved. Small businesses represent a great many very small units--organizations that do not have professional health workers or even personnel staff. They need simple, inexpensive,

transportable health promotion programs.

In 1984, The Travelers established a new subsidiary--the Center for Corporate Health Promotion--designed to specialize in health promotion and medical self care programs. Last year, we began incorporating some of the Center's programs in several of our small business benefit packages. Our "Taking Care" program seems especially well suited to the small business market, because it is a communications based program that could be used in any business, and it is relatively inexpensive. "Taking Care" is based on the idea that health promotion and medical self care are not largely what someone does to you but rather something that you do for yourself as an individual. The "Taking Care" program, through a guide to medical self care and a monthly newsletter and some supplementary self-testing materials, enables employees of any size business to become informed and active participants in their own health care.

While our data is preliminary, Travelers has found that innovative health promotion programs, crafted specifically for small businesses, will generate the same savings that big businesses have already been enjoying for several years. Based on the experience of our small business customers, we conclude that for every dollar invested in health promotion, small firms can save $2.50 in health care expenses.

In conclusion, we believe that there is active competition in the small employer health insurance market. To the extent people are not covered, it is largely due to the cost--cost largely driven by medical inflation. We strongly urge that your Committee consider the value of and encourage managed care, innovative plan design, PPO's, and health promotion, as important options available to small businesses for controlling costs.

Senator **Bumpers**. Thank you, Mr. Manley.

Mr. Shoptaw, on page 4 of your testimony, you state that health care costs in this country are three times greater than Japan and twice as high as Western Europe and yet the morbidity and mortality tables show the outcome is no better here than it is there. How do you explain that? Do you have an explanation for it?

Mr. **Shoptaw**. I certainly do not, Senator. I think that of course if you want to use morbidity and mortality tables, I am sure that there are some that would take issue that this is the true index of quality of health care that we have in this country. I think there is a basic economic issue here. Why is it, particularly as we are moving to more of an international marketplace, that we are having those kinds of disparities. When we look at the fact that 11 percent of the gross national product or over $450 billion a year is going into the health care industry in this country, I think we are beginning to see the fact that as far as the international marketplace is concerned, we are really out of step.

In fact, I just saw an indication in a current publication stating that health care now has become the largest industry in this country in terms of dollar volume.

Senator **Bumpers**. Mr. Shoptaw and Ms. Lehnhard both, did you see this story in the *Washington Post* 2 days ago?

Ms. **Lehnhard**. Yes.

Senator **Bumpers**. Do you want to comment on that?

Ms. **Lehnhard**. I thought you might ask about that. [Laughter.]

Senator **Bumpers**. I assume you were prepared for that.

Ms. **Lehnhard**. Yes. I checked with the Plan here in the District of Columbia and evidently——

Senator **Bumpers**. Just so the record will show, I will insert this statement in the record, the headline of which is "Health Insurance Companies Raising Premiums Sharply" and alluded to the Blues.

Ms. **Lehnhard**. Their rates for small groups are going up between 15 and 25 percent and as the article notes, they have not had a rate increase for 3 years. This increase is not untypical of what we are seeing across the country for all types of carriers because of the increase in medical costs.

The 70 percent increase was for a specific company that, interestingly, has a high concentration of employees who are Medicare eligibles. Because of the recent Congressional changes that say Medicare is no longer primary, that company is now picking up insurance costs for Medicare eligibles that they did not have to pick up previously and their rates are now catching up.

Senator **Bumpers**. I do not understand that last comment. What do you mean—where does Medicare play into this?

Ms. **Lehnhard**. Well previously Medicare paid first for people over 65 who were entitled to Medicare. There have been a couple of changes relating to people who continue to work and are eligible for Medicare. The government has said that now employers must pay first. In other words, the employer pays for their care just like an employee under 65, and then Medicare picks up anything that is left over.

The health care costs for somebody over 65 can be four times higher than somebody who is middle aged, so this is a company that, interestingly, really got hit by that change in the Federal law. This is cost shifting which Mr. Shoptaw referred to, to the private sector.

Senator BUMPERS. When was the law changed on that, last year?

Ms. LEHNHARD. Last year, the law was changed so that Medicare is always the secondary payer. Previously, Medicare had been secondary to age 69.

Mr. SHOPTAW. 69 and above.

Ms. LEHNHARD. So it is about 2 years old.

Senator BUMPERS. Mr. Manley, you said in your testimony that every dollar invested in health promotion—for every dollar invested in health promotion small firms can save $2.50 in health care expenses. Do you mean health care expenses or health care premium costs?

Mr. MANLEY. The study that that information was taken from is a little bit narrower, I guess, than that sentence implies. It was taken from a study where they were measuring impact of health promotion and medical self care materials on the use of outpatient visits to physicians. And indeed when you use those materials, visits to physicians offices do drop off and that is where the savings number came from.

Senator BUMPERS. Let me ask all three of you this question. Hubert Humphrey used to wax eloquently on the floor of the Senate about there being no such thing as health insurance. He said it is sick insurance because it does not come into play until you get sick. And he also used to use an illustration that dealt with the Ford Motor Co. I believe Ford did an experimental study and found that they could save X millions of dollars by requiring all of their employees over 40, for example, to get a medical examination twice a year and everybody under 40 once a year. And they found out that that saved them a lot of money.

But my real question is, if you paid for an annual physical, would that reduce the cost of health care in this country and would it have the potential for reducing premium costs?

Mr. SHOPTAW. Senator, I will take a shot at that first. It is pretty much I think the conviction within the insurance industry that preventative services do work and over a trend of say 5 to 7 years will return the kind of dividend that Mr. Manley talked about. Certainly the HMO type of product line is heavily built around that concept.

What we are seeing as a practical matter in the private health insurance industry is the fact that for example in Arkansas where we have over 200 licensed insurance carriers, that an employer may very well be price shopping his insurance from year to year. It is very difficult unless the employer is willing to pay a surcharge on the existing premium to install those programs that will not have a payoff for 5 or 7 years, for a carrier like Blue Cross and Travelers or anyone else to make that kind of investment, realizing that you may only be on that particular risk pool for a 12-month period.

Mr. MANLEY. I would add a couple of things to that I guess. There are two things operating from our perspective; one is the idea of health promotion in terms of life style behaviors and the impact on that does tend to be a long term sort of impact and there is a lot of debate still about what preventative measures really have a positive cost benefit ratio for the population as a whole. A routine annual physical exam, for instance, is not considered by most people right now to be a cost effective way of controlling health care costs. There are schedules that are recommended by the medical profession that tend to be longer than that for otherwise healthy people.

But yes, we think in the long run you could do that, the problem, as you have stated, is that every individual employer may not get the return.

There is also some evidence that medical self care has a short term impact. People tend to think of medical care as something professionals do but most medical care always has been and really still is self delivered care, if you consider medical care broadly. You think to yourself I have a headache, I've got some choices, I can go to bed and lay down and wait until it goes away or I can take some aspirin or I can go to a neurosurgeon and ask him why my head hurts.

Most people have always delivered their own medical care and the question is can we get them to make more appropriate choices, when to use professionals and when not. There is an immediate payoff in those types of things, that is what we have been trying to incorporate in the "Taking Care 'program.

Senator BUMPERS. This hearing really does not deal with this, but just as a matter of curiosity, is Travelers excluding AIDS from their coverage?

Mr. MANLEY. We are not.

Senator BUMPERS. Are the Blues?

Mr. SHOPTAW. No.

Ms. LEHNHARD. No.

Senator BUMPERS. Senator Weicker.

Senator WEICKER. Thank you, Mr. Chairman.

Mike, of all age groups, children are the most affected by the weaknesses in the public and private insurance systems. In 1984, children made up 25 percent of all Americans younger than 65 and comprised one third of America's 36 million uninsured persons. The majority of these children live in families with a working parent.

I noted in your testimony that Travelers does not offer coverage to the dependents of the smallest participating companies, those under ten employees. This situation combined with the increasing number of employees not electing to buy coverage for their dependents is contributing to the increasing number of uninsured people. I am deeply concerned about the dependents of these employees.

Has Travelers considered addressing this problem?

Mr. MANLEY. Senator, I do not understand where in the testimony we said we do not provide dependent coverage, we do cover dependents of those employees if they want dependent coverage in all our policies.

Senator WEICKER. You do?

Mr. MANLEY. Yes, sir. I will tell you though, based on our experience, medical care costs are sharply different in different parts of the country and I know in some areas of the country with very high medical care costs, dependent coverage is often an option for employees. The employee has to buy that coverage on a contributory basis and some employees are not buying the coverage, but it is offered.

Senator **Weicker**. I have no further questions. Alluding to the article which was referred to by the Chairman, again I really have to wonder what the small business is to do with a 70 percent increase in premiums.

Here is what bothers me on that point. You said, for instance, that the justification in the article for the increase was that premiums had not been raised since 1984. What bothers me is whose fault is that? In other words, the insurance companies get into competition among themselves when interest rates are high and they do not charge appropriately for premiums that cover the care that is to be delivered should illness strike. And then when claims exceed the rates they charged for premiums they try to make up the differences on losses with huge increases in premiums. I am not an expert in insurance, but is this not what really happened in the casualty market among the various insurance companies? For several years they were competing among themselves and offering lower rates. Then it all hit the fan in the form of increased premiums to cover huge losses which just about buried small businesses. Indeed many small companies just had to give it up or close their doors.

Are we seeing the same thing with health insurance? You mentioned this widespread competition, and that insurance companies want the business and therefore seem willing to write premiums without annually reviewing exactly what is actuarily sound.

Ms. **Lehnhard**. Senator, you are absolutely right. When a small company gets hit with that big catch-up cost, it is a surprise to them and very hard for them to absorb. I think what is more likely to have happened in the last few years, however, is that health care cost trends were moderating and we did not perhaps need to increase our rates because the medical care costs were showing a slower rate of increase. In the last few months, however, we have had a very abrupt increase in health care costs that many insurance companies did not anticipate, so it is a catch up for what has happened just in the last few months.

Mr. **Shoptaw**. Senator, if I may, I would like to add a footnote to that comment. Our actual experience in Arkansas indicates that over the last 4 years, the hospital utilization rate per 1,000 population has gone from some 720 days per thousand individuals covered annually to some 450 days per thousand. That drop off at an average cost of $500 per day obviously has made for a situation where dollars were available to offset the additional costs that we were seeing in a per day situation in the hospital and certainly on the ambulatory side. But as we approach the lower limit of how low hospital days per thousand people can go and still maintain quality care, we are going to see costs begin to escalate. And in our opinion we are going to see another major round of health care inflation that may approach the double digit within the next 24 to 36 months, away from the 7.7 percent that we saw in 1986.

Senator **Weicker**. Well that is not a very comforting statistic or my prognosis.

Mike, one final question. If you were not obligated to carry all the mandated coverages that the various States require, could you significantly reduce premiums?

Mr. **Manley**. Yes, Senator, I think we could. We have trouble deciding exactly what the impact is because we have built in a number of so-called mandated coverages into our basic plan when it looked like it was going to be general, but we think there is anywhere between 4 and 15 percent of extra cost in there because of the cost of mandated benefits, it varies from State to State.

Senator **Bumpers**. You know, just one final statement. It is not your fault and it is an entirely different question that Senator Weicker and the rest of us in the Congress have to address, and that is the question I started out with. There is something seriously amiss with our health care delivery system when we spend twice as much as other developed nations, three times as much as Japan for no additional benefits. And the other thing I might say is, the Government shares some of the responsibility for this 35 million people who are uninsured.

In the State of Arkansas, for example we have cut Medicaid to the point now that you are not eligible for Medicaid if you are in a family of three and make more than $200 a month. Millions of people in this Country who are below the poverty line are not eligible for Medicaid. And they represent a very significant part of that 35 million people who are uninsured. We have made Medicaid cuts because of budget constraints, and the net effect has been that the States have had to simply tighten down. They had to either pick up the cost or tighten the screws on who was eligible. You have got to be almost destitute to be eligible for Medicaid in our State.

As we have done that, those figures on the uninsured have continued to climb, so we share some of the responsibility for the very problem we are talking about.

Senator **Weicker**. If I may point out another aspect of the problem, putting on my other hat from Labor/HHS, is how we misspend our money. We spend—the Government spends an average per person in this Country of about $2,000 in health care. We spend $25 per person on research—on research. We are asking for catastrophic health insurance while the administration is requesting cutting the budget of NIH on research. Can you imagine the money, 25 bucks per person. Now you want to talk about putting your money where it is going to give you the biggest payoff. Never mind catastrophic health insurance, we ought to be at the front end of that spectrum in research, so we never get to the catastrophic point.

And there is a very good example as to the misspending of money, $2,000 per personal care, $25 in research. I'll bet you if you had $2,000 in research, you would be spending about $25 in personal health care. I think I would rather be healthy and not have the care. I realize that is an exaggeration but certainly there is a point to be made in those figures.

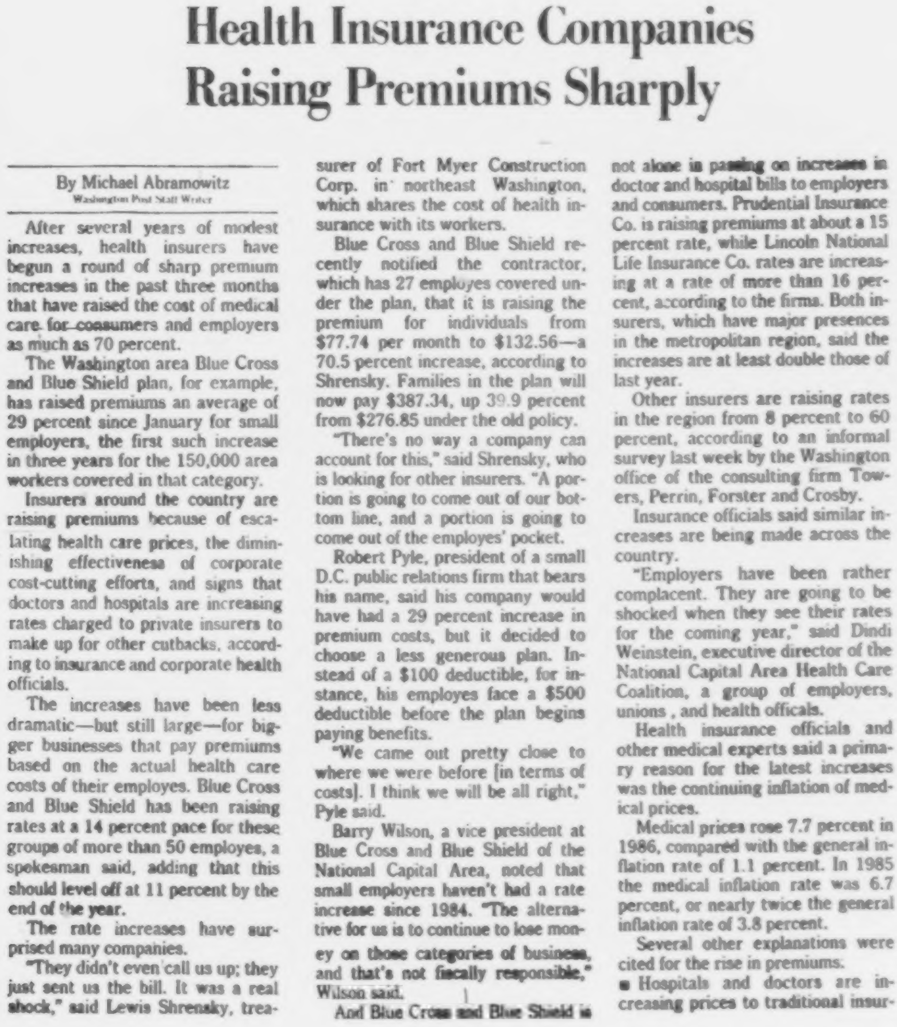
Senator **Bumpers**. Well you know, just to be the devil's advocate on that point, I am told that care for the elderly is one of the biggest problems we have in this Country, people are living longer and they are spending more time in the hospital. I guess research has caused us to live longer which in turn has caused an increase in hospital costs too. But your point is well taken, especially in the field of AIDS, which has threated this civilization like nothing I can remember.

Gentlemen, Ms. Lehnhard, thank you all very much for being with us.

Mr. SHOPTAW. Thank you, Senator.

[Material follows:]

/From the Washington Post, April 20, 1987/



Health Insurance Companies Raising Premiums Sharply

By Michael Abramowitz
Washington Post Staff Writer

After several years of modest increases, health insurers have begun a round of sharp premium increases in the past three months that have raised the cost of medical care for consumers and employers as much as 70 percent.

The Washington area Blue Cross and Blue Shield plan, for example, has raised premiums an average of 29 percent since January for small employers, the first such increase in three years for the 150,000 area workers covered in that category.

Insurers around the country are raising premiums because of escalating health care prices, the diminishing effectiveness of corporate cost-cutting efforts, and signs that doctors and hospitals are increasing rates charged to private insurers to make up for other cutbacks, according to insurance and corporate health officials.

The increases have been less dramatic—but still large—for bigger businesses that pay premiums based on the actual health care costs of their employes. Blue Cross and Blue Shield has been raising rates at a 14 percent pace for these groups of more than 50 employes, a spokesman said, adding that this should level off at 11 percent by the end of the year.

The rate increases have surprised many companies.

"They didn't even call us up; they just sent us the bill. It was a real shock," said Lewis Shrensky, treasurer of Fort Myer Construction Corp. in northeast Washington, which shares the cost of health insurance with its workers.

Blue Cross and Blue Shield recently notified the contractor, which has 27 employes covered under the plan, that it is raising the premium for individuals from $77.74 per month to $132.56—a 70.5 percent increase, according to Shrensky. Families in the plan will now pay $387.34, up 39.9 percent from $276.85 under the old policy.

"There's no way a company can account for this," said Shrensky, who is looking for other insurers. "A portion is going to come out of our bottom line, and a portion is going to come out of the employes' pocket.

Robert Pyle, president of a small D.C. public relations firm that bears his name, said his company would have had a 29 percent increase in premium costs, but it decided to choose a less generous plan. Instead of a $100 deductible, for instance, his employes face a $500 deductible before the plan begins paying benefits.

"We came out pretty close to where we were before [in terms of costs]. I think we will be all right," Pyle said.

Barry Wilson, a vice president at Blue Cross and Blue Shield of the National Capital Area, noted that small employers haven't had a rate increase since 1984. "The alternative for us is to continue to lose money on those categories of business, and that's not fiscally responsible," Wilson said.

And Blue Cross and Blue Shield is not alone in passing on increases in doctor and hospital bills to employers and consumers. Prudential Insurance Co. is raising premiums at about a 15 percent rate, while Lincoln National Life Insurance Co. rates are increasing at a rate of more than 16 percent, according to the firms. Both insurers, which have major presences in the metropolitan region, said the increases are at least double those of last year.

Other insurers are raising rates in the region from 8 percent to 60 percent, according to an informal survey last week by the Washington office of the consulting firm Towers, Perrin, Forster and Crosby.

Insurance officials said similar increases are being made across the country.

"Employers have been rather complacent. They are going to be shocked when they see their rates for the coming year," said Dindi Weinstein, executive director of the National Capital Area Health Care Coalition, a group of employers, unions , and health officals.

Health insurance officials and other medical experts said a primary reason for the latest increases was the continuing inflation of medical prices.

Medical prices rose 7.7 percent in 1986, compared with the general inflation rate of 1.1 percent. In 1985 the medical inflation rate was 6.7 percent, or nearly twice the general inflation rate of 3.8 percent.

Several other explanations were cited for the rise in premiums:

- Hospitals and doctors are increasing prices to traditional insur-

Health Insurers Cite Higher Costs

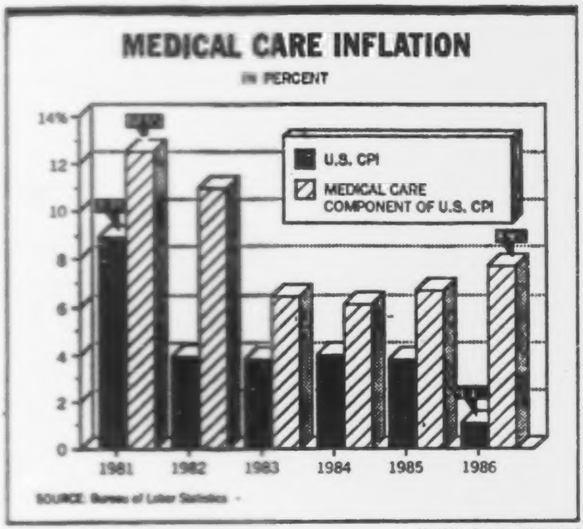
ers and employers offering full-service coverage to make up for cuts in government funding for Medicare and discounts offered to prepaid health plans.

- Cost-cutting measures taken in the early 1980s have shown diminishing returns in terms of savings. These techniques include requirements that employes obtain second opinions before undergoing certain elective surgery and get prior authorization for other procedures.
- Recent declines in hospital use have slowed, while ambulatory procedures and surgery are on the rise, signaling a new source of high costs.
- Feeling pressure for several years from health maintenance organizations and other prepaid forms of health insurance, traditional fee-for-service plans kept prices down more than costs justified to remain competitive. But rising costs are forcing them to abandon this strategy, according to industry observers.

The recent increases in health insurance costs confront consumers and the employers that pay for most of their health care costs with some unpleasant possibilities.

Employers are expected to increase their efforts to shift more of the burden of health care costs to their employes by raising the deductibles and copayments in health plans, officials said. Consumers also can expect greater incentives to leave traditional insurance plans and join HMOs and other lower-cost health plans that limit the choice of doctors and hospitals.

Linda Spear, a benefits officer for Bell Atlantic, which like many large employers insures itself, said that after remaining flat in 1985, medical costs jumped about 10 percent in 1986. Spear said cost increases have been restrained by recent increases in deductibles and copayments charged employes. But she said: "What we're afraid of is that the 1986 [increase] is a trend."



SOURCE: Bureau of Labor Statistics

BY TOBEY—THE WASHINGTON POST

"I don't think that employers are going to stand for [these] kinds of increases" in insurance costs, said Judith Fleming, senior vice president of HealthWin, which markets prepaid plans for Lincoln National. "They will look for a plan that manages their costs better than indemnity plans, or they will reduce the benefits in indemnity plans," she said. Indemnity plans pay for coverage of medical expenses by virtually any hospital or doctor.

Within the past year, most major health insurers have moved to set up lower priced, "preferred provider" arrangements that cut costs by offering incentives for patients to use lower-cost facilities.

Such arrangements may prove popular because they are less restrictive, albeit more expensive, than HMOs. Some employers also have shied away from HMOs, hailed several years ago as a solution to escalating health costs, because of concerns that they are actually driving up the cost of traditional health plans by taking away healthier, less expensive employes.

"The HMOs are largely the cause of the upsurge in medical costs that many employers are experiencing," said Ray Hinton, who is in charge of human resources for Sovran Financial Corp., where about 40 percent of the work force is enrolled in HMOs. "Merely by doing nothing, the cost of the indemnity plan is going to get so expensive that people are going to be forced into HMOs," he said.

In recent interviews, several corporate officials said they believed that medical costs are destined to continue rising unless more dramatic steps are taken.

"Individual [doctors and hospitals] are still free to set their own rates without market economics coming into play," said Robert Dankmyer, director of Marriott Corp.'s employe benefits. "As long as the providers have control of this, you're not going to see a redirection in medical costs."

Senator **Bumpers**. Our last panel is Mr. John J. Polk, Ms. Dorothee Maynard, Mr. Willis Goldbeck. Please be seated and we will take about a 3-minute intermission.

[Recess.]

Senator **Bumpers**. Mr. [illegible]olk, would you proceed.

STATEMENT OF JOHN J. POLK, EXECUTIVE DIRECTOR, COUNCIL OF SMALLER ENTERPRISES, CLEVELAND, OH

Mr. **Polk**. Thank you Mr. Chairman. My name is John Polk and I am executive director of a group called the Council of Smaller Enterprises in Cleveland, affectionately referred to as COSE. I am here on behalf of my members and the other local and regional small business organizations which are members of the National Small Business United.

You have heard a lot of discussion on the macro aspects of the impact of our health care crisis on the small business community generally. I think that one of the aspects of the problem to which we can provide some good perspective is the impact of these issues on real live little companies in our home town. I will give you some of the specifications on our organization and why we consider these issues to be so important.

COSE is the largest local small business organization in the United States, we have about 7200 member companies. One of the reasons that we are fairly large is that we sponsor a fairly significant group health insurance program for members of our organization. Some 4,500 of our 7,200 member companies participate in at least one of the plans that we sponsor through the organization. More than 100,000 employees and dependents receive their coverage through COSE sponsored plans and those individuals and their employers invest about $75 million in annual premiums with our sponsored carriers.

Our group is composed primarily of very small companies, the average employment size of a member company participating in our health plan is eight workers and we have literally hundreds of single contract units within our membership, who obtain the benefits of group health insurance coverage through COSE when it might not be available to them in any other way. Those very small units, those single employee units, what the technicians like to refer to as the onesies and twosies, find it very difficult to obtain group health insurance coverage under most circumstances.

One of the policy issues that I would like to raise here in the context of my remarks is related to that group of very, very small employers for whom access to coverage is extremely restricted. And that is that as the Federal Government considers revolutionizing the health care delivery system by mandating coverage, I would hope that the Congress will consider how the Federal Government—how on earth the Federal Government will design and manage benefit plans which can be enforced and monitored at that mini-micro level of the business population.

Now COSE members save money through our group health insurance plan, in many cases up to 35 percent over the cost of identical coverage available to companies that are not members of our organization. We have managed to produce those savings because of our size and because of our ability to administer our programs on a centralized basis. In other words, we have managed to deal with the primary market related reasons why health care coverage is so expensive for little companies, by combining thousands of little companies into a massive buying group and by centralizing the administration of our plans.

But even so, our members prices can be as high as 40 percent higher than comparable coverage available in larger companies. The reasons for that, discounting the market related factors, are regulatory in nature. They would include Federal regulation such as ERISA restrictions and voluntary employee benefits association restrictions produced by the Federal Government, not to mention COBRA which you have heard a lot about this morning, but which frankly nobody understands how to administer yet, as well as State regulatory factors like mandated benefits and like state insurance laws that require in effect that no matter what size COSE is, as a benefits buying organization, we must still buy retail, however at a discount from our insurance carriers.

That is a second policy point that I would like to address here today, and that there are both market-related and regulatory factors which make is difficult for small companies to buy benefits efficiently in the marketplace. And these are problems which will not be resolved by mandating benefit coverage.

COSE's plan is designed to include as many small companies as possible. We are an unusually wise open plan. As I mentioned, we can provide health insurance coverage and write it down to one life in a company. But even so, in order to keep our members' costs in line, we have had to institute some minimal cost control measures, things like age rating, a special program for substandard risks in our program, medical underwriting for companies with fewer than 10 employees, and even though fewer than 5 percent of the companies that apply for coverage through our sponsored plans are actually rejected, those who are rejected find themselves without coverage for medical reasons.

Now these standards; age rating, substandard rating and medical underwriting, while they have apportioned costs more fairly throughout our entire group in general, they do cause some inconvenience and expense to some small companies. No matter how well COSE designs its plan, we cannot design it well enough to cover everybody without losing our shirts.

And that is a third policy point I want to summarize. The plans bandied about by Congress currently, by Senator Kennedy and others, which features things like community rating, no medical underwriting, extremely low deductibles, will never be able to be priced fairly enough to provide the kind of coverage the proponents intend without losing tens of millions of dollars per year. There is a fundamental difference here between people who need insurance; that is, people who are making an investment against an unforseen future event, and people who by dent of medical necessity are seeking a lower cost subsidy for medical care which they are certain to require. So there are two different kinds of needs to be dealt with in the uninsured community, different needs for different constituencies and they cannot be accommodated in a single strategy, especially not if the cost of that strategy is to be borne entirely by the business community.

Finally, and most importantly, I want to reinforce one of the comments that the chairman made in his opening remarks. There is a big misassumption on Capitol Hill that the reason that most small employers that do not offer group health insurance coverage do not provide that benefit is that small employers are somehow greedy and that they have made a conscious decision that by not offering group health insurance coverage, they will lower their labor costs and gain some competitive advantage and that is frankly hogwash, and by saying so, I might be demeaning hogwash.

It is absolutely true, based on our experience, that everybody wants group health insurance coverage. And the way the small group marketplace works, entrepreneurs cannot deny their employees health insurance coverage without foregoing coverage for themselves. The way health insurance is underwritten in the small group marketplace, insurance carriers will rarely accept partial groups in the small group marketplace. You provide coverage for everybody or you do not provide coverage for anybody. Price is not as big a factor as people think. Our experience, particularly in areas like substandard risk, leads us to believe that where the coverage is available, people will buy it at whatever price.

The primary issue is that good health coverage is simply not as available for very small employers as we might think. And there are a few reasons. We have spent a great deal of time talking today about the tax discrimination that exists in the Code against unincorporated companies. That is very important. Medical underwriting rules, also very important. An insurance carrier can reject an entire small group for coverage if even one or two of its employees have previously existing medical conditions. Alternative delivery system providers, such as HMO's and preferred provider organizations, some of those cost-saving alternatives, rarely market their services to very small companies. And frankly commercial carriers are reluctant to provide that coverage to very small groups.

And I will give you two good examples of how I know that to be true. Four years ago, the Council of Smaller Enterprises shopped its entire book of health insurance business, at that point about $50 million in premiums among 65 of the top insurance carriers in the country. We received proposals from not a single one. We received a lot of nice letters from a lot of carriers indicating that for various reasons they were reluctant to provide health insurance benefits to small companies through associations.

Up until 3 months ago, COSE offered its members the opportunity of participating in three programs sponsored by three different HMO's. We received a letter about a month ago from one of those HMO's indicating that the health maintenance organization had been acquired by another company and that that company would be discontinuing COSE's HMO program. Why? Because the HMO did not want to do business with small businesses and did not want to do business with associations.

We are dealing with problems fundamentally of access, of supply, and they cannot be resolved by legislative demand as Senator Kennedy and his committee proponents propose to do.

What health care mandates will do is require small companies to buy high risk, high priced coverage from carriers who may have rejected them previously for medical reasons or for other reasons, but those carriers will, since companies would have to have coverage to open their doors, be compelled as their patriotic duty to help those small employers out at an appropriate price.

Those mandates would also create a horrendous new Federal bureaucracy which even in summary is unwieldy, it would be charged with designing 50 different types of plans or their actuarial equivalents with six different options in each State of the union, would be charged with designating administrators and monitoring contract relationships, would be charged with approving companies' benefit plans or their actuarial equivalents and would also be charged somehow with controlling the prices to keep those federally designed, federally approved, all-inclusive plans affordable for small companies. I consider that to be simply an impossibility.

I would like to suggest as an alternative a few less revolutionary steps which would be aimed at making group health care coverage more available and more affordable in the voluntary marketplace, which works pretty well when you get right down to it, some 80 percent of employers are providing some kind of group health insurance coverage to their employees today, voluntarily, in the voluntary marketplace.

The first and most important step we have already talked about, and that has to do with ending what is ridiculous discrimination in the Federal tax code against unincorporated small companies. There is simply no reason that a partner or a sole proprietor should not be able to take a business deduction for what is a legitimate business expense, and if the Government expects to encourage more small business owners to purchase that coverage, the Government should be prepared to extend the same incentive to small proprietors that they provide to corporate officers.

Second, I suggest that we take a very close look at regulatory reforms which will enable small companies to buy more efficiently their group health insurance coverage, especially through associations. I talk about reforms to ERISA, particularly taking a look at voluntary employee benefits associations. There are rules that define homogeneity standards among groups of employees that can band together for self-insurance. I wonder if those rules could be restricted somewhat. We talked a little bit this morning about restoring the ERISA preemption from State regulation for association insurance plans that qualify. And there are lots of other reforms that might involve State action that would be germane to dealing with this problem.

Third, I wish we could find some ways to encourage more carriers to be more creative in the small group marketplace, particularly the HMO's and PPO's. I will remind you of the experience that I summarized just a minute or so ago. There is no reason on earth why a plan like COSE which represents 100,000 people that is 100 percent credible in actuarial terms, represents $75 million in premiums, should be considered untouchable by commercial carriers who do not want to do business with associations like mine.

Finally, and this is a recommendation that is perhaps best kept for a better world. There is probably a need for some kind of comprehensive sense of direction regarding this nation's health care policy. It does not exist, at least from the viewpoint of the guy from out of town.

We can deal with this burgeoning crisis in health care in two alternative ways. The first way is to continue to do patchwork work that will be achieved by legislating as much as our elected officials can get to extend coverage on a mandatory basis to individual target populations within our economy. The second alternative is to take an entrepreneurial and political risk and that is to bring together government, both State and local, representatives of the business community, of labor, the insurance industry, of the provider groups to try to establish some uniform national sense of direction with regard to how we will provide Americans with better access to the health care system and render those services in a more cost efficient and cost effective way. As I say, I recognize that there are some political risks to doing so, but given the resounding failure of our previous attempts to resolve this crisis through more patchwork means, it appears to me that it is a risk that we are less and less practically inclined to ignore.

I could go on about these issues for days on end. I think it is probably best for me to sort of shut up, pass the baton and wait around to answer questions.

[The prepared statement of Mr. Polk follows:]

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STATEMENT

OF

JOHN J. POLK

EXECUTIVE DIRECTOR

COUNCIL OF SMALLER ENTERPRISES,

VICE PRESIDENT

GREATER CLEVELAND GROWTH ASSOCIATION,

AND

MEMBER OF

NATIONAL SMALL BUSINESS UNITED

TESTIFYING ON

HEALTH CARE BENEFITS FOR SMALL BUSINESSES

BEFORE THE

COMMITTEE ON SMALL BUSINESS

UNITED STATES SENATE

WASHINGTON, DC

THURSDAY, APRIL 23, 1987

1155 15th Street N.W. Suite 710, Washington, DC 20005 (202) 293-8830

Mr. Chairman, Committee members, my name is John Polk. I'm the Executive Director of the Council of Smaller Enterprises, a division of the Greater Cleveland Growth Association, Cleveland's Chamber of Commerce. On behalf of my own organization, and of the many other local and regional small business groups with which we're affiliated through National Small Business United, let me begin by expressing our deepest thanks for the interest and concern which this Committee has begun to express on this most important issue. As our elected officials both in Washington and in state capitals throughout the country begin to mobilize to address what is rapidly becoming a crisis in health care, it is absolutely vital that policymakers understand the impact which proposed reforms in our health care delivery system will have on the nation's small employers, so that in crafting a solution to this burgeoning crisis, we avoid making serious, costly, and counterproductive errors.

I'm sure you'll be hearing from others today who can be more precise and articulate than I about the "macro" aspects of our current problems. Our perspective is not so benignly detached; it comes of more than a decade of providing services to our member companies at the grass roots, of attempting to answer their questions, solve their problems, and make the system work better for them company by company, day by day. We'd like to think that COSE represents the real world in this discussion, and that we speak from a strong understanding of how small companies behave in the health care marketplace, and how the health care marketplace interacts -- or fails to interact -- with the small business community.

Our dedication to member service is a principal reason for COSE's growth into the nation's largest local small business group. Our 7,200 member companies employ nearly 150,000 Greater Clevelanders. More than 4,500 of our 7,200 companies purchase their health care coverage through one of eight plans sponsored by our organizations. Those companies purchasing plans through COSE will spend more than 75 million dollars in premium with our sponsored carriers, and those dollars provide coverage to nearly 100,000 employees and dependents. Companies purchasing plans through COSE are generally very small. The average number of employees is eight, and we have many, many member companies with three or fewer certificate holders. COSE is the only group in Greater Cleveland, and one of very few in the country, which can provide sponsored coverage to a company with only one eligible employee, and still provide that qualified single employee with the flexibility and cost savings of group coverage. And this is the first key point I want to raise for your consideration today, one which the macro planners and policy-makers frequently overlook: the major problem of access to the health care system for small companies exists at the lowest level of the marketplace, and the most fragile and volatile...the very smallest companies. Most carriers will write small group coverage down to companies with 25 workers; some will write down to 10 employees; but few carriers outside of Blue Cross/Blue Shield plans will write under ten. Nobody likes the "onesies and twosies," and their need is the greatest of all. I submit that no-one in the Federal government can develop standards which are manageable at that level of the marketplace.

Those member companies which purchase plans through COSE save about 35 per cent over the cost of comparable coverage available to non-members. Those cost savings are a combined function of our sheer size and of the efficiencies of our program of centralized administration for all sponsored plans. These are two of the primary market-related reasons for limited coverage in the small bsuiness market, and we've done the best we can to address them. But even with those efficiencies, the costs of our plans average about 40 percent higher than the cost of the average large-employer plan. That cost differential is not a function of the marketplace: mostly, it's a function of regulatory impediments which limit COSE's flexibility and power in the marketplace. Those regulatory impediments are both state and Federal in nature. They include such diverse problems as ERISA restrictions which make it administratively unfeasible to self-insure or totally self-administer, state regulations, especially mandated benefits, and provisions which require that, whatever COSE's size, we must buy retail from our carriers plans which have been designed by others. That is a second key problem: there are both market-related and regulatory factors which make it extremely difficult for small companies to design and purchase benefit plans in the most efficient possible way, through combining their buying power through Associations.

Since we don't have the flexibility that large employers do, COSE has been forced to try to control costs -- and allocate them more effectively among our member companies -- through more conventional means. We have been forced to institute a variety of programs over the past five years which have benefitted our plans overall, but which have posed hardships to individual member companies. Programs such as age rating and substandard risk rating allocate costs more fairly for the COSE membership generally, but have raised rates dramatically for companies whose employees are either elderly or higher-than-average utilizers of services. In the past three years, we've begun rejecting groups whose employees have chronic, severe medical problems. It's true that we're way more flexible than most insurance plans -- only about one in 20 companies are actually denied coverage -- because our standards are designed to be as inclusive as possible, to permit as many companies to participate as we can -- but that still causes problems for member companies whose employees suffer from heart disease, diabetes, emphysema, and other disorders. Painful as these measures are, they are still necessary to protect the integrity of our plan. And even with these measures, costs are difficult to control.

This is a third key policy issue which you must consider, particularly as Congress and state legislatures consider mandating companies' participation in a health plan, or in the design of "risk pool" programs: no matter how generously a plan is designed, it must somehow provide cost-control safeguards, however minimal. The concept of a plan which requires community-rating and permits no medical underwriting simply ignores the reality that the needs and problems of small companies and their employees are different. It also ignores the fundamental distinction between people who need insurance -- that is, who make an investment as a hedge against an unforseen future event, and those who are buying a subsidy for a certainty. The needs and problems of those constituencies are different, and even if our elected officials designed the best plan in history for those who need insurance, it will be inadequate for those who require a subsidy. In many states, "risk pools" are the intended vehicles for such a subsidy, but because state regulation governs only fully-insured plans, their costs are -- unfairly -- borne only by those who buy health care coverage from insurance carriers -- predominantly small companies.

So...we have problems in the marketplace. We have regulatory problems which impede our efficiency. We have instituted safeguards which make our plans more inconvenient and expensive for some than for others. And yet still, members continue to buy their health plans through us. Why? Two reasons which are related, and which address my final policy consideration. First, if you're running a company in Cleveland, Ohio, and if you have to compete for employees, you have to have a health plan. And for many of these employees, COSE is the only alternative. I've already mentioned that commercial carriers are reluctant to deal with small companies, except under tightly restricted conditions. It's also true that alternative delivery systems, such as HMOs or PPOs, generally don't make their services available to small companies. So for many of our members, COSE is the only game in town.

The final policy issue I want to raise is this: everybody wants group health care coverage. When Senator Kennedy and Senator Weicker met with a few of us two months ago to discuss Senator Kennedy's new proposal, his staff began the discussion with the assumption that many small employers do not provide coverage to their workers because of some competitive decision that not providing employee coverage would save labor costs and provide the company some kind of competitive advantage. That assumption is simply hogwash (and by saying so, I may be demeaning hogwash). It is a false assumption for two reasons. First, at least in my part of the country, where competition for qualified labor is intense, health care coverage is the most important non-wage benefit a company can offer. If you plan for your company to grow, you must offer the benefit. Secondly, and more to the point of the entrepreneur's self-interest, given the restrictions on the small group marketplace, carriers won't sell coverage to partial groups; if the entrepreneur decides not to provide group coverage for his employees, he decides to forego group coverage for himself.

The problem is essentially one of supply. If a small company doesn't offer coverage to employees, chances are it's because the coverage simply isn't available. Price isn't as big an issue as you migh think. The high price of health care is a symptom of other problems, both market and regulatory factors. But, when it is available, people will pay just about any price for coverage. The primary reasons why small companies don't offer coverage are: 1)lack of incentive for the smallest firms to offer coverage, due to discrimination in the tax code against unincorporated entities; 2) underwriting factors which enable carriers to reject an entire small group for coverage if even one employee has a medical problem, and 3) limited participation by conventional and alternative carriers alike in the small group marketplace.

The Congress cannot solve problems of supply by legislating demand, as Senator Kennedy proposes to do. Legislation which would require employers to offer and pay for coverage for employees and dependents as a condition of doing business will not solve problems of supply, and will certainly not deal with the issue of cost. What it will do is both blow the lid off health care costs, especially for small employers, insured and uninsured alike and create a new layer of bureaucracy and regulation which, even in its simplest summary form, is conceptually horrendous. Not only would such legislation not solve the problem; it would permit its proponents to lull themselves into some self-congratulatory delusions that they had solved the problem until a huge crisis came crashing down on them.

As we have before, let us make a few suggestions which might address the problem of the availability of group health care coverage in a less revolutionary way. Instead of focusing on demand, let's focus on supply, on a few things the Congress might do to make coverage more available -- and affordable -- in the voluntary marketplace.

The first and most important step the Congress could take would be to restore the deductibility of an investment in group health insurance premium for the principals in unincorporated companies. My understanding of the census data on which health care assumptions are being made is that about 6 million of the forty million Americans without health insurance are believed to work in small companies. I'd bet anybody here a dollar that the majority of those six million employees work in sole proprietorships and partnership arrangements -- very, very small companies. If Government's concern is that those individuals cover themselves and their dependents, Government should be prepared to provide those individuals with treatment under tax laws equivalent with corporate tax treatment for the same investment.

A second recommendation would be to examine the regulatory impediments which make it difficult for small companies to pool their buying power and purchase their coverage more efficiently by Association. At the Federal level, that action would involve a review of ERISA rules, especially. You might consider, for example, amending ERISA to extend its pre-emption provisions to association plans that qualify. You might also consider relaxing restrictions on the homogeneity of groups to be covered under VEBA arrangements, as another example.

A third recommendation would be to consider what steps might be taken to encourage both conventional carriers and alternative service delivery system providers with more of an incentive to do business with associations. I'm not sure what those steps might be; I do know that, four years ago, when we shopped our then-$50 million book of business among the nation's top insurance carriers, we received proposals from none of them. I also know that one of the HMOs with which COSE does business has just been acquired by another company, and the new parent company has advised us that our plan with our HMO is being discontinued. The reason, in both cases, is "we don't do business with associations."

There are some other issues which would improve small business' access to the health care system, largely requiring state legislation, which are not particularly germane here, though I'd be happy to discuss them, if you wish.

I have one final recommendation, one which, I fear, is perhaps best reserved for a more ideal world. Is it possible, rather than attempting to address this important issue on a patchwork basis by legislating as much as our elected officials can get away with, that we could all -- government, both state and federal, business, labor, the insurance industry, the provider community -- develop some consensus, some common sense of direction, for our nation's health care policy? Legislative attempts to deal with these issues, both here and in state capitals around the country, as abhorrent and wrong-headed as they often are, are nonetheless an attempt to deal with at least the symptoms of a real and burgeoning national crisis. We feel it acutely in Cleveland, Ohio, where our health care costs are about the fourth highest in the nation. We are all partially to blame for the depth and breadth of the problem. None of us -- especially the business community, which is paying the tab for so much of this -- can continue to deny the existence of the problem any more. I'm just one guy from out of town, but it's pretty clear to me that there are two ways of dealing with this problem. One way, the way we're dealing with it now, is to continue to point blaming fingers at different sectors as the primary causers of the problem (last year it was the doctors, this year its small business), and pass cost shifting legislation which will punish the target group for awhile until it's somebody else's turn to take the blame, and bear the expense. The other way is to discuss the issues in a responsible and public forum, with input and participation by all segments of our society, and see if we can craft a lasting solution. I think I recognize the political risk -- to members of Congress, and certainly to small business -- in attempting the latter process. But considering the resounding failure of attempting to solve the problem in the former fashion, I for one believe that we're rapidly reaching the point where we'll have no choice but to take the risk of establishing a reasonable dialogue in pursuit of some rational policy.

I hope to be able to answer any questions.

JJP/hcr
04/15/87

Senator BUMPERS. Thank you, Mr. Polk. Ms. Maynard.

STATEMENT OF DOROTHEE D. MAYNARD, PRESIDENT, THE GOOD NEIGHBOR ALLIANCE CORP., CRANSTON, RI

Ms. MAYNARD. Thank you very much for inviting me, Senator Bumpers. I am impressed—this is my first attempt to give testimony and I am impressed by the interest in small business.

I am the president of a small company that employs seven people and what we have attempted to do in The Good Neighbor Alliance is to unite small business people who are primarily from one to six employee companies. I started approximately 5 years ago realizing that small companies do not have anything as far as advertising, buying power, they have no assets whatsoever but their own ingenuity to start a business.

So what I did 3 years ago through the demand from the small businesses was to unite the small business effort and take it to an insurance carrier. I had approximately 600 small companies three years ago and I brought the prospect of taking those 600 and their employees to an insurance company asking them if I take responsibility for the management of this paperwork burden, which as Mr. Polk mentioned, is primarily a problem with large companies insuring smaller companies, they do not want the responsibility of having to take the smaller companies, insuring them and having the swinging door which we know happens in a small company, employees come and go and it is a paperwork nightmare for an insurance company to consider.

And for some reason they also rate us very high on the scale of risk. I do not believe that, I would like to see statistics, but somehow insurance companies say that small business people are high risk as far as health insurance. And I have had this also directed to me, as Mr. Polk mentioned. I have been turned down by four separate insurance companies for group rates also.

Now presently I represent—I took the responsibility of all of the paperwork and I represent 2,600 companies. Out of the 2,600 companies, I have 83 percent who participate in the group health. That group's health performance represents approximately 15,000 people who have now access to group rates which they never had before. We also have a double level. The one to six employee companies have a group rate which is a standard rate regardless of their age, their sex, their marital status or the number of children involved in the family plan. They have given us an across-the-board so to speak rate. The people who have—or the companies who have from 6 to 25 employees are rated individually on their own age, sex and marital status and then those people have access to the rate. The biggest problem with the individual grouping is the entire company can be accepted or rejected on the pre-existing conditions of one employee. If the pre-existing conditions are severe enough, which would be an overweight condition, a high blood pressure condition, a pregnancy—which to me these are not extreme pre-existing conditions—the entire group is rejected.

How I faced that problem is what we do is take the people who are rejected and eliminate them and take the others and put them into The Good Neighbor Alliance grouping, which those people would be eligible. So what I have done is virtually taken my own initiative to adjust the insurance situation, which addresses small business or which does not address small business in many cases, and I have addressed it through group identification.

One of the problems I have with mandating would be if you mandate that small businesses have access or mandate that they insure their employees, now you have a problem of access. I differ with the Travelers insurance representative. We probably could get it, but the amount of money it would cost us and the deductibles are incredible. Small business people have a much higher rating, and I am not sure again why, they tell us the risk factor is involved. So that again, we are paying more for the product, we are expensing more, our expenses are much more than larger companies, and it is right across the board. It is right from the beginning of opening your company to the day that you close your company, you pay more for everything.

So I feel that small business people, the fact that I have 83 percent participation, they do care about health care, they are interested in their employees. For instance, my employees, I have seven, those people are my business. Without them, as you probably can remember your hardware—without these people, you are nothing. Try running it yourself, it does not happen. So you have to address health care, you have to address benefits. So the small business has not eluded to benefits, small business just has not had access or has not had the funds available to them to get the benefits.

I feel that if we address the problem in two ways, one of the ways suggested here would be to have a group catastrophic program that every employee is mandated to take part in. In Rhode Island, we have a TDI program, I understand not every state has it, but Rhode Island has a TDI program where we pay one percent of our weekly salary into a program and we are assured that if we are out of work we will receive some type of compensation.

Now my suggestion and other suggestions which have come down to me through my companies because I did put this out as a test of how they would feel about it, I have not heard anyone complain about the TDI. In fact, most people do not even realize it comes out. So that if we had a general catastrophic fund where each employee would participate, it would be a state managed fund so that these funds could be invested, such as my company does with funds, invest the funds and these funds could again be kept for the uninsured, those who are not employed and everyone employed would have catastrophic. Now it would be up to the Government to decide what the minimum coverage would be, whether it were $25,000, $30,000, $40,000. But at least the primary care of the catastrophic problem, which is one of the greatest problems that we are facing because if you do have a coronary, if you do have cancer, if you do have an existing condition over a period of time, it does amount to a catastrophic number. That is one of my suggestions.

The other suggestion is that Government encourages insurance companies to work with associations. One business by themselves cannot address the insurance issue and qualify the insurance coverage needed. My company takes that responsibility away from the individual businesses by assessing the groups or the insurances that come to us, we assess the coverage and decide whether this would be something that these small business people could afford. This would be something—I have 18 years of medical background and this is an asset to me to judge whether the insurance proposal is a good proposal for coverage. I have dealt with Blue Cross and I have dealt with the HMO's and I am of your thinking, I feel that preventive medicine is the only medicine that we should address.

And I also am in sympathy with the research, if we could get more research, we could save more lives. However, the problem before us is the existing problem of coverage and I think that needs to be addressed in both of these ways. If we could have a general fund that would be state managed and we could also have minimum coverage that each person who is employed would be responsible for. And then small business would have to assume the paperwork, they would have to do the paperwork as far as the payroll deductions and make another deposit, which is also a burden to small business. So it would be a burden, but the entire cost of mandated benefits would result, I feel, in most of your small businesses under ten employees to disappear and as far as the entrepreneur effort, they can teach entrepreneur in college but it will not help if we do not open the doors for someone to open their own business and reduce the burden of cost and reduce the burden of responsibility on us.

I thank you very much and I will be open to questions. Thank you.

[The prepared statement of Ms. Maynard follows:]

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The Good Neighbor Alliance Corporation

1664 Cranston Street / Cranston, Rhode Island 02920

Dorothee D. Maynard
President

TESTIMONY OF

DOROTHEE D. MAYNARD
THE GOOD NEIGHBOR ALLIANCE CORPORATION

Before: **Senate Small Business Committee**
Subject: **Mandated Health Benefits**
Date: **April23, 1987**

I am before you today as President of The Good Neighbor Alliance Corporation, a former delegate to **The White House Conference on Small Business** and a representative of more than 2,600 **small business** owners who subscribe to my company's services.

The Good Neighbor Alliance serves as a resource to small businesses, primarily those having from one to twenty five employees. Our services range from group health benefits to state/wide advertising, workshops and seminars on business management, and business to business referrals. All of our programs are designed to promote **small businesses**, reduce their costs, and save the business owner time.

Three years ago The Good Neighbor Alliance identified **health care benefits** for employers and employees of small firms as a major problem. Many of our members complained about the cost of health care and the inaccessibility of **group rates.** Our solution was to form a group of Good Neighbor members, and take responsibility of marketing, billing, and managing the paperwork, in exchange for group rates by the insurance carrier. Approximately 50% of our Alliance members joined the program during the first year. Presently, 83% of our members take advantage of this group rate health care program.

The Health Care Issue

The health care issue of the un-insured is a complex one that cannot be solved by a mandate. The uninsured working population is primarily employed by small firms. These firms are not opposed to health care nor are they opposed to offering it to their workers. They simply have not had access to plans that offer **group rates**, as well as, varying levels of health care options and premiums.

We all agree that the government itself, with its many resources, cannot afford to pay the premiums for the un-insured, and I am here to testify that the **small business** is also unable to pay the premiums. (We, small business owners, realize this is a problem and we have been troubled and concerned by it.) Most small firms not only fail to cover their employees with health benefits, but also leave their own families at risk.

Facts

The real facts facing **small businesses** are that they pay a larger portion of taxes, they pay more for goods and services, and they have more competition and less resources than their big sisters and brothers. They also have a higher experience of employee termination due to the inability to be competitive with salaries and benefits, therefore; **small business** spends a considerable amount on training employees.

For years the small business owner has been aware that benefits are a part of employment, and must be considered along with salaries and the cost of doing business. The real fear is if benefits are mandated, the bargaining and mutual needs of the employer and employee will not be a consideration. The employer will loose the ability to offer what he can afford and the employee will feel cheated of what he needs.

If mandated benefits are allowed to become law, we can expect the following consequences:

- **An increase in bankrupcy of small businesses.**
- **An increase in unemployment.**
- **An increase of the work load on remaining employees.**
- **An increase in the price of goods and services to the American public and one more factor prohibiting small business from trading on the world market.**
- **A decrease in salaries and raises for employees.**
- **A decrease in small business' ability to spend money on training the unskilled and unemployed.**

To re-inforce the effects of what a mandate would do, I give testimony from business owners I recently polled.

The owner of A. & J. Pallet Co. expressed himself as follows, "I am tired of having to fight to make ends meet. I am not encouraged to expand nor am I encouraged to continue by the **tax reform, workers compensation insurance, and the pressures** of running a business. I'm seriously thinking of selling or just closing shop." This businessman employs 40 people and has been in business for more than thirty years.

Another business person recently stated that business is just getting too sophisticated for him. The rules, regulations, taxes, employee management problems, O.S.H.A., restrictions, cash flow pressures, and competition are much greater than the meager compensation that his business is able to pay hem. "It's just not worth it," he said.

A combination of managing health care benefits for small business owners, plus the personal sharing of experiences and ideas, have taught me many things about small businesses that I never would have realized. Small business owners have a high regard for their employees in general. They realize that the employees' dedication and hard work are the main ingredients needed for success.

The following plan is my solution to the health care problem before us:

A. The government mandates a catostrophic health plan, managed by each state and financed through employee payroll deduction. All business must support the paperwork burden of this program through payroll deductions and enrollment of each employee.

B. The catostrophic plan would enable each employee to have coverage for a minimum contribution and each state would have a considerable amount of funds to invest and cover the expences of health care incurred by the presently uninsured.

C. With catostrophic insurance in place, each employer could petition group insurance carriers for group premiums less the catostrophic coverage. The reduced premiums would make health care benefits more affordable to everyone, including; the business owners who would like to offer benefits but previously could not afford to and simply did not have access to.

D. The catostrophic program would have a deductible and a maximum amount of annual premium to be paid by all employed persons. (Similar to Rhode Island's Temporary Disability Program, which is 1% of weekly compensation up to a total of $116.00 maximum contribution per worker annually.)

I believe that health care is a problem and premium cost a major part of the solution. Therefore, by spreading the cost and making insurance accessible to all, the master is served without slaughtering the lamb.

Senator BUMPERS. Thank you, Ms. Maynard. Mr. Goldbeck.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, DC

Mr. GOLDBECK. Mr. Chairman, it is a pleasure to be here. My name is Willis Goldbeck and I am president of the Washington Business Group on Health, which is an association of very large employers. Wwe are here in two capacities today; one is hopefully to be an information resource to you and your Committee and in that context have tried to provide some fairly voluminous appendices to our actual statement so that you will have the record of what has been learned in large companies, many of whom I might parenthetically add function as small companies in their various locales around the country. The other is to comment on the three areas which you have addressed; health insurance itself, cost management and prevention.

I would also add that Business Group itself is a small business. We are a DC corporation of less than 25 full-time employees and have every headache that you could possibly have heard illuminated here today, and there are some very real and substantial problems.

You made the comment earlier with one of the other witnesses that was it not possible that we pay as a society in many respects for these costs already because of the uncovered population. The answer is unequivocably yes. The issue is not doctors and hospitals that do not get paid. It is who else pays for those who do not have the money to pay themselves. And to a very substantial degree, part of that cost shifting is onto those large and small businesses that do provide health insurance. So one of the principal issues to have one's eye on as we deal with this problem of a subset of the population in the employed sector is to not create solutions that are penalties on those who, by great effort in many instances, are doing precisely the kinds of things the Government says needs to be done anyway: Providing the right coverage.

We have a basic issue here, whether or not we want to adopt policies that strengthen employment as the distribution vehicle for the health care services in this country, or whether we want to move more directly toward Government as that distributional vehicle. If we do not want more Government in the active role as the distributor, and certainly the membership that I represent tends to believe that as a matter of principle, then we have to face up to the reality of closing the gaps in the employment sector itself. And the largest gap is in small firms, although it would be unfair to not recognize that there is a growing problem of part time, leased workers and other categories of workers in large firms as well.

I do not think it is realistic to suggest that we can close those kinds of gaps by establishing pools or taxing methods which, once again, only end up increasing the costs for those employers who now provide all the benefits voluntarily.

I do think that you as a Committee need to consider strongly the nation's investment strategy to get value for health care dollars. And if you do that, you will inevitably come to support an investment in prevention. The experiences that we have found with large corporations are now well past the point of being challenged for their accuracy. In the appendices we have provided over 200 examples of corporate programs that pay off, that have been studied in all sorts of different ways. You can question one study's validity or another study's validity, but it is very hard to question hundreds and hundreds of studies' validities, none of which have any economic incentive to be proven good because those companies are not selling them, they bought them. So they only have a reason to find out accurately if they paid off and they find out consistently that they have paid off.

It is also true that when we talk about methodologies of providing insurance for small business, it is unfair to say that small business simply cannot afford health insurance. As SBA's own testimony provided, the majority of small businesses in fact do provide health insurance. So it is a categorical set of problems that need to be addressed, not a uniform problem for the entire nation.

Certainly we do have some lessons that are valuable and aggregating little companies into large groups is an essential step. You have heard from the folks to my left that there are barriers to making aggregations of small businesses an efficient purchaser of medical care. Those barriers are Federal and State. Those are imminently correctable problems. If you take away these problems you are still left with the reality that small business should not buy insurance by itself. It does not make any sense for someone with five employees to try to compete with Goodyear in the insurance market—it just does not make sense, particularly if we are going to continue a system of commercial insurance products where profit is a part of the system. So aggregation is essential.

It also is true that a lot of the problems you have heard about have more to do with regulating the insurance industry than regulating small business. The tax deduction issue is clear and I just want to be on the record as a large employer organization, we also favor having the parity in tax deductibility that the small organizations themselves have spoken so·articulately about.

I do want the record to be clear that despite the philosophical objections to mandates in general, there is growing sympathy among some larger employers when the alternative proposals so frequently talk about only taxing those who already provide the insurance. When employers hear that, as was proposed frequently last year and is now the way that is being proposed in many States, the idea of a uniform minimum mandate is a better economic buy for many of those large companies even if they do not like it philosophically.

We have learned a lot on the cost management agenda and there are many things that are available both to small and large business. But, the truth is that large business has a great advantage in the ability to buy intelligently, and this shift from insured buying to the actual purchase of medical care is a far more important shift than just a transfer to self-funding—or self-insurance, as it was referred to in earlier testimony. The critical point here is that the large firms and the large unions are now buying medical care, not just buying insurance. I think that is what the aggregations of small firms have to be able to do, not just negotiate for a better premium, but to be able to buy units of care and negotiate with hospitals and doctors.

And so, once again, the message becomes clear: Remove any legislative or regulatory barriers to the enablement of functioning large group buyers of small businesses. The separate businesses will not be the buyers, the groups will be the buyers.

In the prevention arena, fortunately it is not necessary to address prevention only through insurance. In fact, any small business that does not have health insurance can still do a lot to increase their employees'—one or more—ability to deal with a preventive agenda. There are examples of that in the accompanying documents. Suffice it to say that we know very well that the provision of information, as Travelers put it, is a very important factor—Travelers is not the norm in that in the insurance industry, they are an exception. We do know that simply the provision of a shower, the recognition of alternative hours of work, the recognition that it is important for women to be able to bring a baby to work on certain occasions, the recognition that lifestyles in this country have changed and work styles have to change to accommodate them, are all important factors of prevention. No smoking policies are the single most effective no smoking program, and by definition costs not one dollar. So the opportunity to work in the prevention arena, as you are familiar from both the work that you and your wife did on the immunization agenda, is tremendously important and pays off extremely well.

I think it is important to note that the speed with which the Congress wishes to address this issue will significantly define the options before you. If you wish to close all the gaps next year, you do not have a lot of choices. You are either going to mandate or you are going to do a national health plan. On the other hand, if you want to have a more evolutionary approach, you can remove the barriers to large groups, change the tax policy, establish some form of a graduated tax credit to address the cash flow problem, and reward prevention. Further, you can selectively decide whether to subsidize or regulate providers and carriers because you have got to deal with both the supply and the demand side. You cannot deal only with one side of an economic equation even via a mandated approach. If you are going to study State health plans, like Wisconsin is considering, and find out through a Federal research program what really works at the State level, that cannot happen in a year or two. But the knowledge accumulated will be of unestimable value.

Let me suggest that, in closing, the movement toward mandates has a considerable amount of strength in it and there are some things that should be on the record if you are going to move to mandates, whether or not we want you to. One should be that there truly is a minimum benefit, not a description of a maximum benefit in minimum terms. A minimum benefit might be a basic catastrophic plan set at an affordable rate, and that can be designed as long as you have enough people in the pool. Societally we might choose to include one long term investment and that would be prenatal care. The evidence of the economic efficacy for all concerned, and therefore employers and their community as well as for their outlay for employees, is absolutely clear that the prenatal investment need be made. And then a responsible level of cost sharing, certainly not mandated to be more than 50 percent, for any other benefits the employer and employees chose through negotiation to purchase for their own system.

To make a minimum mandated benefit work one would have to preempt all state mandates, COBRA and non-discrimination. You cannot have a system that mandates that employers provide a specific benefit to follow the law and then charge them with discrimination if they also do something else for an employee. You cannot mandate a minimum benefit and simultaneously mandate ten maximums that they must also accept. It would be contradictory public policy.

The lesson from large business that is applicable to small is that a multiple approach is needed. There are no successful large employer health programs that do not blend cost management strategy with prevention programs with access to new forms of medical care, and new forms of coverage such as case management, HMO's, PPO's. In other words, no longer accepting the pure indemnity model. If all of the Fortune 500 companies in America in 10 years have decided and have used evidence to reaffirm that the indemnity only model did not work, we do not need the Federal Government to come in now and mandate an indemnity only model for the small businesses in America. We need a multi-form approach with the emphasis on prevention to represent the long-term investment in health that this Nation needs as a balance to short-term solutions to the access issue.

Thank you very much.

[The prepared statement of Mr. Goldbeck follows:]

Washington Business Group on Health

Health Insurance and Preventive Services:
Problems and Opportunities for Small Business

Testimony Provided To
U.S. Senate Committee on Small Business
by
Washington Business Group on Health
Willis B. Goldbeck
President

April 23, 1987

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My name is Willis B. Goldbeck and it is my pleasure to appear before you today as President of the Washington Business Group on Health. The WBGH is a national organization which represents the health policy and economic interests of very large employers. Because our members are the nation's largest employers, I want to begin by clearly stating why we accepted your invitation and feel our participation in a hearing focused on small business is most appropriate.

1. 100% of our members provide extensive health insurance benefits to their employees and dependents. More than 95% cover their retirees. Every person who utilizes the medical care system without insurance or the resources to pay full charges out-of-pocket becomes an additional cost to our members. Bills not paid become liabilities to the very employers and unions which provide the best coverage as the provider's "losses" are shifted to those who do pay. Solutions to the medically indigent problems (pools, sick taxes, provider cost shifting etc.) typically help the provider at the expense of our members rather than really solving the problem.

2. Our members want to see the U.S. maintain a health system which is based on employment as the primary distributional mechanism. They want a collaborative system with government, not a government system. Government has three main roles to play:

   a. public health and research

   b. providing access to needed and appropriate care for those who cannot gain access through employment provided coverage or other private market methods

   c. facilitating the expansion, equity and efficiency of the employment based system of coverage

3. Consistent with this philosophy, we believe that the public and private sectors have to work together in a constantly evolving health care system. From the experience of recent years, we can state with confidence that:

   a. The key to increasing affordable health insurance for small business is to aggregate buying power.

   b. Cost management technologies developed by large employers over the past decade are applicable to small employers, but the value is proportional to the size of the group, again reinforcing the contention that the main focus of public and private policy is to encourage the aggregation of small groups into large purchasing units.

   c. Prevention programs are a wise business investment for firms of any size, with or without insurance, and provide short as well as long term benefits to both employers and employees.

Reviews by WBGH staff on the following topics are attached to this statement:

1. The extent of health insurance coverage, with an emphasis on small business and the problems which seem to keep these employers from providing coverage. (Appendix I)

2. Health promotion program efforts by small business and relevant lessons from programs offered by large employers. (Appendix II)

3. Cost management program experience that can be helpful to small employers. (Appendix III)

We have extensive supporting material on all three topics and will be happy to respond to any further questions the committee may have.

Insurance Availability (Appendix I)

Our appendix provides the latest details from which several highlights emerge.

First, the purchase of indemnity insurance by very small firms is not only very expensive, it is also a poor value for both employer and employee compared to comparable coverage for larger firms.

Second, because the price is high, the product relatively poor and the purchase entirely voluntary, the market for small business insurance is considerably reduced.

Third, small firms are constrained in their ability to manage insurance costs since their workers are grouped by the carriers. Note that this is very different than would be the case if the workers were aggregated by the employers prior to the purchase of the insurance.

Fourth, given the above highlights and the tax disadvantages for self-employed and sole proprietorships, it is amazing so many small firms provide coverage at all.

Fifth, any plan to require a minimum insurance benefits must be phased in over a considerable period to avoid significant business and job losses.

Sixth, the future growth of employment in the U.S. will be in the small business sector thus indicating that the use of employment, as opposed to government, as the primary health insurance distributional system, will be increasingly dependent upon an equitable national solution to this problem.

Cost Management (Appendix II)

Major employers now have a decade of experience in cost management. Much of what has been learned is relevant to small business. And, foremost among these "lessons" is the need to aggregate buying power. Small firms do not have the staff to manage health care costs and make use of the opportunities available to larger groups. We use the term cost management, rather than cost containment, precisely because success depends on a philosophical and economic commitment to manage the purchase and use of medical care. To do so requires time, expertise and assigned responsibility; communication with workers, retirees and dependents; negotiations with carriers, health plans (HMO, PPO, CMP etc.), hospitals, physicians and non-physician providers. Small firms cannot devote the staff to this level of management and, were they to do so, buying care for only a few people severely limits the savings opportunities. The message is clear. For small business to gain the cost management opportunities that have proven successful in large business, they have to buy care like large business. To do so means aggregating into large groups to increase market leverage.

Cost management can be viewed as a series of trends, each of which has implications for small business. Additional information and examples are provided in the appendix.

1. Employers have shifted from being payers of insurance premiums to buyers of medical and health care. The switch from insurance to self funding; direct negotiations with hospitals and medical groups; HMO-PPO contracts; in-house pharmacies, preadmission testing, and even surgical suites;

case management; and employee consumer education programs are manifestations of this change. All of these options are based on the economic buying power and administrative support associated with large groups... but none are dependent upon those large groups being from the same employer.

2. Employer acquisition and analysis of health care data is the single most essential element of cost management. Again, success is dependent upon large groups. Without price and quality comparative data the economic advantages of choice and competition are meaningless.

3. Benefit plan design changes include many which can be as cost effective for small business as for large:

   a. Hospice
   b. Cost Sharing
   c. Employee Assistance Programs
   d. Wellness Programs
   e. HMO

   In many cases, small firms are in a "buy" situation where large firms have the "make" alternative. All of these benefits can be purchased in most communities, all have been proven to be cost effective, and all can be designed to fit local conditions.

   Plan design innovations like PPOs, flex plans, triple option and case management are less amenable to very small groups.

4. Benefit controls are also more difficult to apply to small groups. Some, like second opinion and preadmission certification requirements can be conducted by the carrier so firms of any size can benefit. Others, such as

utilization monitoring, and mail order prescription drugs are designed for large groups.

5. Evidence of effectiveness is much harder to obtain for small groups where a single case can skew the results and the total utilization is too small to be statistically evaluated.

Prevention (Appendix III)

The U.S. will not have a successful, accessible or affordable health care system as long as it is totally dependent on the traditional acute medical care model. We must balance the increasingly successful efficiencies of a market oriented medical care delivery system with an investment in the preventive and social services that are essential for improving health, decreasing dependence and avoid wasting billions on inappropriate acute care.

For the past ten years, the WBGH has been advocating worksite wellness and employee assistance programs. We have also been tracking the results and it is most encouraging to report real progress. Many of you may have seen press coverage of the recent four year study of 15,000 Control Data Corporation employees.

This study validates that those whose life styles are prevention oriented incur dramatically less medical care expenditures than do their counterparts who smoke, or do not exercise, or who are overweight. These findings match the results of the recent evaluation of the Johnson and Johnson wellness program which showed that life style interventions do reduce health insurance expenditures as well as improving morale and increasing productivity. Our appendix provides many other examples, some of which are explicitly from small employers. A few points deserve to be highlighted:

1. Any firm, no matter how small, can provide some preventive services. Time to exercise, assistance with a stop smoking class, referrals to an employee assistance program in the community, a shower, good food in a vending machine, distribution of free wellness literature from groups such as the American Cancer Society... all these and many more cost very little and are not even dependent upon having medical insurance. Company policies, like no smoking, are free and can be very effective.

2. Those with insurance can provide economic incentives for healthy life styles by altering co-payments or deductibles based on behavior. There is every reason to believe that these workers will perform just like their peers in larger firms where program evaluations have already been done.

3. The Public Health Service will work with small employers to assist with the provision of such preventive services as immunizations.

4. Even the smallest firm can adopt a work culture that contributes to good health and reduced medical care utilization.

Mandated Benefits

The threat of mandated benefits is by far the most contentious issue concerning small business and health insurance.

The organized voices for small business are unequivocable in their opposition to any mandate.

Many large employers have mixed feelings.

Virtually all are philosophically opposed to any mandate that interferes with private compensation. Benefits are a part of compensation and thus should be left to the employer-employee relationship. Many also fear that mandated minimum health benefits will quickly expand and become the vehicle by which Congress attempts to reduce the deficit by the false savings of unilaterally shifting costs to employers. Recent history with Medicare and COBRA provide strong substance to the legitimacy of this concern.

As concern for the ability of U.S. firms to compete in international markets grows, so does the opposition to mandated benefits which are viewed as governmentally created burdens totally contrary to our economic objectives.

Large employers have traditionally been very reluctant to support government controls on smaller employers.

Despite these deeply held concerns, there is growing pressure on large employers to accept at least a modified approach.

With some two-thirds of the medically indigent being in the work force, it is not possible to deny the charge that the employment based insurance system is threatened more by employer reluctance to participate than by government interference. More than half of the nation's small employers do provide some measure of insurance protection. Therefore, the argument that such coverage is unaffordable based on the size of the company is proven wrong by their own experience.

When employers traditionally accepted the "socially responsible" position that they should assist in paying for the care of the poor, they did not anticipate that these philanthropic and tax dollars would be used to subsidize the workers of other employers who thus gain a competitive advantage over those who voluntarily offer coverage.

The concept of pools, where the losses would be recovered by charges or taxes on those firms which provide health insurance, is so blatantly unfair and such an incentive for more firms to drop - much less start - benefits that, in 1986 we recommended the drastic step of distributing these losses across all employers... including those that did not provide benefits. I mention this so you will fully appreciate the extent of the change in large employer attitudes.

As more large employers find their profit margins shrinking, their responsibility for retirees growing, their mandated coverage for people no longer in their employ expanding, and their health care expenditures soaring at a rate five to fifteen times the rate of CPI growth, their attitude is shifting to take a more societal view of health economics. This seems to be inevitably leading to one of two conclusions:

a. Treat all the uncovered as a societal problem and finance their care by general revenue taxes.

b. Increase the coverage provided through employment, even if that means acquiescence to a mandated minimum benefit.

This is such a touchy issue, I want to be very clear:

1. A majority of our members would oppose mandated minimum benefits on philosophical grounds.

2. This opposition is not even half as strong today as it was only a year or two ago. Reasons, in addition to those stated above, are:

    a. Most of our members provide benefits which far exceed a truly "minimum" design and thus would not be economically hurt by the mandate.

b. 100% of our members will benefit financially if all employers provide at least minimal coverage thus reducing the indigent care costs which are now shifted primarily to companies which provide the most extensive voluntary benefits.

c. A mandated minimum benefit, to be economically feasible, would have to result in the retraction of the COBRA benefit extensions. Small firms cannot reasonably meet these requirements and it is the fear of just such requirements that fuels the political opposition to any government mandate. If Congress is serious about a mandated minimum as a condition of employment, then the COBRA and non-discrimination rules-(in tax reform) must be removed or at least redesigned. Obviously, if the law mandates a minimum, it is not reasonable to punish an employer who follows the law and also elects to provide some workers with more than the legal minimum.

Alternatives to Mandates

Mandated benefits are never the desired approach for business. They also seem to be a much easier solution than is actually the case. For every mandate there is a price that may not be paid by the social account in question (in this case access to health care), but will be paid by other impacts on the economy, on employment, on small business entrepreneurial development, and on the diversity which is so central a component of the American work and community culture.

If they can be made to work, incentives are always preferable to mandates. Options do exist. The number of small firms that provide health insurance is ample evidence that it can be done. Aggregation of small firms, professional groups and the self-employed are not new, they are just not sufficiently prevalent. The tax deductibility of health insurance is an underutilized tool that can be selectively applied by Congress not only to help the self-employed gain parity with larger firms, but also to reward firms that invest in prevention programs or that join purchasing groups to increase their buying power and cost management options.

To be specific, Congress could declare a national objective of having all employees and their dependents covered by employment based health insurance by a target date, say April 23 1997, a decade from today. A graduated business tax credit could be established that would start with the provision, by an employer, of the federally designated (but privately sold) minimum plan. The refusal to provide the minimum would be an employer's right but would result in a tax on that employer to cover the cost of 50% of the care actuarially estimated to be incurred by those employees. I say 50% because that could be established as the national base for employer's contributions.

The graduated tax credit would increase as those employers who did provide insurance added preventive services, cost management systems and more expansive benefits thus reducing the risk to the government (and therefore to the tax payer) of minimally covered employees resorting to public programs.

Special long term social objectives for which the economic benefit is societal, such as prenatal and well baby care, could receive special tax benefits.

An alternative or perhaps supplementary approach would be for the federal government to provide financial incentives directly to health plans that sold these benefits at affordable rates to small employers. Other alternatives, such as mixing private insurance with Medicaid buy-in options, also exist.

Any ideas such as these require extensive review and scrutiny by all interested parties. Our point is only to show that the rush to mandates, while understandable and increasingly attractive to many is not the only way to achieve the objective I believe we all hold: access to, and acceptance of, adequate and affordable health care by all working Americans and their families.

Washington Business Group on Health

APPENDIX I

SMALL BUSINESS AND HEALTH INSURANCE

prepared by

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The Employed Uninsured

Eighty-five percent of the 100 million Americans in the work force obtain their insurance through their employer. This results, at least in part, from the fact that U. S. tax laws make it advantageous for workers to take part of their compensation as a tax free fringe benefit. According to 1984 Federal data, 62 percent of the entire population was covered by a health insurance policy obtained through a family member's place of employment. Of the $341.8 billion spent on personal health care in the U.S. in 1984, private health insurance payments accounted for about 31 percent, more than Medicare and Medicaid combined.

However, in 1985, this still left 35 million civilian nonagricultural people under age 65 reported no health insurance coverage from any source. (All future references to this universe will refer to the civilian, nonagricultural population.) This means that

- o 55 percent (17 million) of all uninsured were workers;
- o 15 percent of all workers report no insurance coverage from an employer health plan. Most, but not all, of the country's 35 million uninsured are associated with these uninsured workers;
- o When dependents of these working uninsured are included, 69 percent of all uninsured are in families of full-time, full year workers. For most of the uninsured in families of full-time, full-year workers, the principal family earner experienced no unemployment in 1985.

Most uninsured employed work full-time, full-year. Among this group, 69 percent earned less than $10,000; 92 percent earned less than $20,000.

In general, the uninsured employed tend to be

- o low wage earners,
- o semi-educated individuals,
- o those employed in small firms,
- o employed in agriculture or service industries rather than in manufacturing,
- o part time workers, seasonal workers, or self employed,
- o earning near the minimum wage.

Small Businesses As A Force In Our Economy

In 1982, there were 4.72 million small businesses (under 500 employees) in the US. An additional 7.5 million workers are either self employed (4.5 million) or are farm proprietors (3 million).

Almost 60 percent of all employed people in the US work in businesses with between 2 and 500 employees. Broken down,

- o 13.6% work in businesses with 100-499 employees;
- o 14.0% work in businesses with 25-99 employees;
- o 30.3% work in businesses with 1-24 employees.

Small businesses create one-half of the jobs in America, produce 43 percent of the Gross National Product, and account for nearly one-half of all goods and services in the country.

Many small businesses tend to attract an atypical workforce. For example, elderly workers are more likely to work for small than large firms. In 1983, just under 80 percent of all workers 65 years old and over were employed in small firms. This figure dropped from 90 percent in 1979; this may be a result, in part, of the 1982 amendments to the Age Discrimination in Employment Act (ADEA), which requires firms with 20 or more employees offering health insurance to also cover workers aged 65 to 69.

There also is a tendency for low income workers to work in small firms. For example, 3.4 percent of the wage-and-salary work force in small businesses had Medicare coverage, compared with less than one percent in larger firms. Thus changes in the Medicare payment provisions could increase employer health costs more in small than in large firms.

Small Businesses and Health Insurance

Employee benefit coverage varied significantly from large (over 500 employees) to small firms (fewer than 500 employees) in 1983.

In large firms,

- 72% of employees had retirement pensions;
- **85% of employees had direct health insurance;**
- 65% had both pension and direct health insurance.

In small firms,

- 26% of employees had pensions;
- **54% of employees had direct health insurance**; and
- 23% had both pension and direct health insurance.

Broken down further, sixty-five percent of the firms with fewer than 100 employees offer health insurance, and at least 40 percent of the firms with fewer than 25 employees offer health insurance.

But even among firms offering health insurance, all employees may not be covered. Following are 1983 statistics showing the percent of employees included in their employer's health plan.

- In firms with 1-24 employees--38.7% were included in health plans.
- In firms with 24-99 employees--65.4% were included in health plans.
- In firms with 100-499 employees--75.2% were included in plans.
- Firms with 500+ employees--85.4% of all employees were included in plans.
- In all firms--67.2% of all employees (including part time) were included in health plans.

Secondary coverage (usually through a spouse) increased the coverage in all size firms.

- In firms with 1-24 employees--66.4% of all employees (including part time) had primary or secondary coverage.
- In firms with 25-99 employees--80.2% had primary or secondary coverage.
- In firms with 100-499 employees--86.7% had primary or secondary coverage.
- In firms with 500+ employees--91.8% had primary or secondary coverage.
- In all firms--81.8% of all employees (including part-time) had primary or secondary coverage.

Only 28 percent of self-employed persons were covered by their own health plan in 1982. When indirect coverage, such as a spouse's plan, is included, 46 percent were covered. Thus, a total of about 4 million of the unincorporated self-employed went without health insurance coverage.

One out of three workers in small businesses have no health insurance, compared to only one out of 10 in large firms.

Health coverage tends to be lower in rapidly growing sectors of the economy, such as services, with its above-average concentration of younger and part-time workers.

Characteristics of the small business work force and worker preferences also stand in the way of achieving higher levels of employee benefits in small businesses. More young workers; lower salaries, more part-time, more "secondary workers", that is second wage earners; young employees prefer a higher salary rather than more comprehensive benefits.

Factors Preventing Small Businesses from Purchasing Insurance

While no national data have been collected, available evidence suggests that a major reason for the difference in availability and comprehensiveness of insurance for small and large groups is that insurance is more expensive for smaller firms than for larger ones. This is because:

- o smaller firms must spread the risk over fewer employees, thus their premiums for a given benefit package are generally higher than those charged to large firms;
- o smaller firms tend to have narrower profit margins from which to pay these higher premiums;
- o under the graduated corporate tax rate, the tax advantage of offering health benefits is less for small businesses;
- o smaller firms also may pay higher costs per employee because the administrative costs of providing health benefits do not significantly increase with the number of individuals covered. Consequently, larger firms enjoy economies of scale unavailable to smaller firms.

In addition, many employees of small businesses are secondary wage earners, covered under health insurance policies of a spouse or parent. Thus there is little or no pressure on some businesses to offer insurance. Their employees would rather have increased wages.

High employee turn-over also detracts from many small business's need or desire to provide health insurance. Two additional reasons for small businesses not purchasing insurance are that they feel their firms are not profitable enough to afford it, and/or that their small company does not qualify for a group policy.

Lack of time and knowledge about health insurance options also work again small business's increased participation in providing health insurance. A survey recently found that the median time spent by small businesses in investigating health care options within the last 12 months was about four hours or one half day. Over 40 percent of those without insurance spent less than one hour looking at health care options.

An added barrier exists for those small businesses that might be interested in purchasing preventive benefits if they knew about them. The vast majority of policies available to small businesses do not include them! Further, most agents and brokers either do not know enough about preventive (and health promotion) options to describe them when asked, or, because they get very little extra commission for selling these additional services, they do not voluntarily present them as attractive investments.

Costs of Insurance to Small Businesses

The administrative costs of benefit plans are relatively fixed, requiring about the same time and expense to establish a plan for 5 as for 50 employees. One study shows that it costs a small firm about $1,080 per employee, but a large firm pays only $574 per person to establish a pension plan.

The size of a firm also affects the share an employer pays for health insurance. Small firms were much more likely to provide 100 percent coverage than were larger firms. In 1983:

	All	1-24	25-99	100-499	500+
Paid all	46.7%	52.5%	46.1%	47.2%	44.7%
Paid part	49.4%	40.7%	49.5%	49.6%	52.4%
Paid none	3.9%	6.8%	4.4%	3.2%	2.9%

Because they are unable to spread the risk over many employees, small firms usually pay higher health insurance premiums than large firms. Higher employee turnover may also be a contributing factor to small employers' higher premiums.

Typically, insurers are less willing to underwrite a generous benefit package for a small plan than for a larger plan. Changes in rules and regulations also have imposed disproportionate costs on small businesses. ERISA has substantially increased the administrative cost and benefit cost of pension coverage for small businesses. A 1977 Department of Labor report states that as a result of ERISA, administrative costs for small plans (with fewer than 100 participants) increased 72 percent. Plan terminations in 1975 (due largely to ERISA requirements) occurred primarily in small firms.

The rise in health care costs has been more severe among small business benefits, with annual premiums rising as much as 100 percent for firms with fewer than 200 employees. This is due to less flexibility in selecting, managing and designing health care plans with cost containment features, fewer resources to develop cost containment programs, the inability to take advantage of group insurance alternatives, and the disproportionate number of elderly workers who face higher health costs.

ODPHP-WBGH Small Business Insurance Project

In the winter of 1987, the Office of Disease Prevention and Health Promotion, U. S. Department of Health and Human Services, asked the Washington Business Group on Health prepare a report on the current status of health insurance availability and coverage for small businesses, and to make recommendations for steps that could be taken to encourage small businesses to voluntarily provide health insurance for their employees. Following are some highlights from the background interviews conducted for that report.

Comments from Insurers

Based on the changes being made by insurance companies, HMOs, and other providers, it appears that the number of carriers actively and aggressively marketing to the under 200, under 100, under 50, and under 10 lives groups, and the options for coverage available to these group, have increased dramatically in the past two to five years.

Insurers now view small groups as a major business segment. While most have sold to this market before, virtually all are placing a new, stronger emphasis on it. They see small groups as the growth area in the future. As a result, the small business market has recently become a highly competitive market, at least in terms of the numbers of packages available. Both these new developments appear to be related to the facts that more and more large businesses are self-insuring, and that over 50 percent of all new jobs are being created in small businesses. As a result, significant numbers of insurers are putting increased energies into selling to the small business market.

However, there is no doubt that all products for small businesses are more expensive than the same package for large businesses. This is due to several factors, including the fixed costs of administering a plan regardless of size, and the added potential liability associated with spreading the risk among a small group.

Unlike the large group market, the small group market is "price-driven," with small businesses more likely than large to select a package based solely on price. In addition, small businesses are likely to change carriers more than large businesses to obtain even a fractionally lower priced package.

Insurance companies have placed an increased emphasis on the importance of this market within the past two to five years in one of several ways.

- By entering a new category within the small group market (such as entering the 2-9 lives group, when previously they insured only groups with 10 or more employees);
- By creating a new division, unit, or "company within the company" focused exclusively on the under 200 market; and/or
- By expanding the options available to their small group clients, many of which had been "only for large groups" until recently (such as by including cost containment features or alternate delivery options).

But packages for small businesses often look much different from those designed for large businesses. Special characteristics have been selected by the insurer to assure profitability in the market, but may actually be barriers to the purchase of that insurance by the small businesses, themselves.

For example, almost all carriers have standard benefits packages for small groups that cannot be altered by the purchaser (except for standard options, such as a choice of a $50, $100 or $200 deductible or co-pays). It should be noted that the "unalterable" nature of small group packages is one of the main differences from large group packages; because of their size and the competitive nature of large group insurance, large businesses can negotiate for "almost anything" in their packages. However, many carriers are increasing the number of different packages available to this market. In addition, they are increasing the types of standard options available within each package.

Experience rating by age within a group insurance policy is an important development in the health plan market from the insurer's point of view. In offering these plans, employers reduce the subsidy of older workers' premiums by younger workers through experience rating within their group policies. For small businesses with a young work force, this will result in lower premiums; for those with an older workforce, rates will be higher. As was mentioned earlier, the number of older workers employed in small firms dropped from 90 percent in 1979 to just under 80 percent in 1983, possibly as a result of the 1982 amendments to the Age Discrimination in Employment Act (ADEA), which required firms with 20 or more employees offering health insurance to also cover workers aged 65 to 69. It is possible that small businesses may respond to age rating--and accompanying higher insurance premiums--by replacing older workers with younger employees.

A survey of Blue Cross Plans conducted by Blue Cross and Blue Shield Association identified rating by sex and age as one of the factors that has been critical in the Blues' successful expansion into the small group market. The Blue Cross survey also identified the increased use of medical group underwriting (the practice of requiring each individual to take a physical exam, allowing the insurer to screen out high medical risk individuals), and comprehensive major medical product (covering both doctor visits and hospital care, eliminating the need for two separate policies), as reasons why their small group products are successful. Many commercial insurers also identified these, especially medical underwriting, as keys to success and profitability in the small group market.

Although most insurers agreed that preventive services make a great deal of economic sense in large groups policies, with the exception of one insurer, preventive services are not seen as a major component of their present small group packages.

Some also do not see merit in attempting to include preventive services in future small group packages. A variety of reasons were given.

- Preventive services raise the cost of the premium, thus force the price of the policy too high to be competitive.
- Preventive services produce long-term, not short term gains, which may not be seen for at least three or four years. Because small businesses notoriously switch carriers more often than large businesses (often changing carriers every two or three years, seeking the lowest premium), and because most preventive services incur costs in the initial year they are offered, the carrier cannot make money by offering them to small businesses.
- Equally important, the small business may not directly reap the benefits of improved health among its own employees resulting from preventive services. This is because many small group are "pooled" (often by the carrier) in order to obtain a better "group" rating than would be possible without such pooling, and to spread the risk over a greater number of individuals and companies. Thus a 50-employee business may find itself in a 5,000 employee pool. Even if 25 percent of its employees improve their health statuses, it would not be reflected directly in the company's rates (since that company's 12 employees with improved health would have little impact on the total pool of 5,000 employees). Yet they would have paid a higher rate to obtain the preventive coverage. If the 12 employees are not pooled and thus "group or experience rated with other small businesses," the company will be "community rated," that is it will be pooled with the entire community; thus here, too, the impact of 12 healthier lives would be lost in the much larger group.

- One insurance company representative said they do not offer preventive services because of "conservative underwriters" who are slow to start anything innovative. Their main concern is holding down costs in a highly competitive, price sensitive market. However, he felt new approaches would be necessary in the upcoming years in order to maintain their competitive edge.

Only one company interviewed for the report stated they use preventive services as a major element to "differentiate" their product from the competition. "The importance of prevention is part of our company's philosophy." The representative of this company viewed many of the reasons given by other insurers for not offering preventive services as merely excuses, stating:

- Many small businesses do want preventive services, and they seek out our company because we provide them.
- Any preventive service can be added to a policy and the cost factored into the premium.
- Preventive services do not add significantly to our premium price.

According to the company representative, in order for it to continue to be successful, its policy holders need to understand the preventive services they receive, and their employees need to understand how to use them. The company also offers some health promotion services, but sees a major responsibility for health promotion resting with the employer.

Because most insurance agents are compensated on the basis of sales, there presently is very little incentive for them to discuss the availability of preventive service options (even though they may carry a marginal additional premium), and, in most cases, there also is no incentive for them to discuss the merits of using the carrier's health promotion materials and services.

Small employers experiencing strong competition in recruiting high-quality employees, such as high tech companies, are among those most likely to seek out preventive benefits. Benefits are an important competitive edge for this type of employer. Gas stations, which depend largely on part-time employees and which do not require a high level of education or skills in their employees, do not experience this type of competition for employees. Thus, benefits in general are not especially important to them.

A recent survey of Blue Cross Plans showed that 37 of 63 Plans responding to a survey provide some or all of the components of a comprehensive health promotion program to their local accounts. An additional 17 are developing or considering developing such programs. And a 1986 survey by the Health Insurance Association of America found that 24 percent of responding companies market a health promotion program for group policyholders.

However, most insurers do not view the health promotion option as an important element in differentiating their product or in influencing small businesses to purchase their product. In general, insurers feel that health promotion is very valuable to both large and small businesses, but because of the problems involved--including high costs--it should be provided to small businesses by the employer, not through insurance.

Comments from Businesses

Virtually all business representatives interviewed believed that the availability of good health insurance coverage at a "reasonable" price was a problem for small businesses in their areas. Most business representatives saw the cost of insurance for small businesses as being the crux of the problem. For example, one individual who runs an insurance association stated that the prices a very small business (often 10 or fewer employees) could get through his organization were 35% below what they would pay on an individual company basis, but that this cost was still 40% more than a large business would pay for comparable coverage.

It was more difficult to pinpoint the question of "availability" of coverage since most business people equate high costs with lack of availability, because they see "available" as including low or reasonable cost.

Therefore, while the numbers of packages and options available from insurers is increasing, it may not be having the desired effect of increasing the numbers of individuals covered, because costs are still too high to make health insurance affordable to many small businesses, especially those with 10 employees or fewer.

Many groups, even those representing only larger companies, recognized the inequities in the present system related to health insurance for small businesses and felt it would be to everyone's advantage to remedy some of those inequities. Most recognize that steps to encourage incentives for small businesses to provide health insurance for their employees will help large employers as well. They were interested in receiving updates on national legislation affecting insurance benefits, and most reacted positively to learning more about how business groups around the country are marshalling their resources to influence health insurance legislation, regardless of the actual positions the local group takes.

Some business representatives view underwriting practices as a significant roadblock to the availability of coverage. For example, the use of medical underwriting--viewed as a very positive development by insurers--can eliminate an entire organization from coverage, since many insurers require that all employees be part of the coverage package (especially in very small businesses). Thus one employee with an existing medical condition can make coverage unavailable for an entire company. Some stated that when a business has been refused by one carrier, most other carriers will not consider writing coverage.

Washington Business Group on Health

APPENDIX II

PRIVATE SECTOR HEALTH
COST MANAGEMENT STRATEGIES

prepared by

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Health Cost Management

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I. INTRODUCTION

Cost management, or as it is more popularly known, cost containment, is not a new concept. Ever since the employee benefits explosion during World War II, employers have been tinkering with benefit designs that attempted to control costs without limiting the actual benefit. However, two major differences separate the period of the 1940s-1970 from the current period which one might roughly identify as having started in 1974.

First, the earlier period was founded on the ideology of giving benefits to increase access to services, thus representing a conscious effort to increase people's ability to utilize services while separating them from having that utilization restrained by the cost of the service. Today, the emphasis is exactly the opposite. We are, in effect, recognizing the economic consequences of being too successful in meeting the objectives inherent in that access-oriented ideology. Demand and supply have risen virtually unchecked by the normal rules of economics and in little relation to real need or any rational allocation of resource to either meet real needs or provide services in the most cost effective ways available. The climate today is dominated by the pressures of costs that seem to rise inexorably in a period of declining resources, an aging population, and a vox populi that, at least according to many political interpreters, calls louder for cost restraint than for increased access to care.

Second is the dramatic increase of governmental involvement, especially at the federal level, as measured both by the impact of the mid-1960s creation of Medicare and Medicaid and by the growth of regulatory programs in the mid-1970s that were a multi-faceted attempt to control costs. Throughout this period, the role of government as the largest single payer of medical care costs legitimized the regulatory efforts, as reflected in the creation of such programs as health planning and PSRO, and investment in developing alternative delivery systems such as health maintenance organizations. However, the government's attempts at cost regulation have been more than counteracted by increases (some would say excesses) on both the demand and supply sides and the continuing effort to guarantee access to care and improve the quality of care. Without regard for the relative merits or values of any of these efforts, the fact remains that today, and in the forseeable future, the emphasis has switched from attempting to regulate costs while improving access, to one of reducing expenditures while accepting the harsh reality that such reductions will mean reduced access.

In sum, government is saying that it will stop paying for both insurance and programs that had, until recently, been deemed to be within the purview of federal responsibility. The states and the private sector are expected to assume responsibility or accept reductions in protection and service programs. Simultaneously, the government is attempting to design and subsequently put into law, changes in the economic incentives that govern the way consumers individuals and their collective agents like employers) buy care, and the way providers (hospitals, other institutional settings and all categories of physician and non-physician professionals) sell their services. Many embrace "market forces" rather than public or private entitlement as the way to ultimately control costs. Nevertheless, cost management will continue to be necessary, and some would say increasingly esential, regardless of the degree to which the nation or individual states adopt or aschew the competitive system.

Private sector employers, especially the very large companies, have been faced with the same progression of cost increases as the government. In fact, since all government health insurance and programs are financed through tax dollars derived largely from payroll and corporate taxes, it would be safe to say that the major employers have borne the primary burden of the cost increases. The big companies have one distinct advantage over the government'when it comes to taking action that is designed to produce improved short term cost management. Since so many of the major employers have already granted medical benefits at or near 100 percent coverage, they have been able to address their cost management objectives without the conflicting need to expand access that traditionally plagues governmental efforts. Small business aces exactly the opposite situation with demands to provide basic insurance far exceeding demands for cost containtment.

It is the purpose of this paper to present an overview of the major [illegible] management efforts. Though a few public sector examples are cited, the paper focuses on private sector initiatives from 1974-1984. There are courses of action taken by private sector employers in their efforts to become prudent buyers of medical care services and insurance that could be transferable to the public sector and may, in the long run, prove to be of greater value for society than the legislative/regulatory approach. On the other hand, initiatives from the private sector may represent the template by which state mandates can replicate the success of these efforts by business.

It should be stated at the outset that this paper is not an attack on regulation. During the past few years, many private sector employers have found significant value in selected regulatory programs. In addition, these same programs have made many hospitals dramatically improve their own planning and management, consequently influencing an improvement in the quality of medical care in their communities. Those in the private sector must acknowledge that the government has multiple responsibilities, many of which, such as cost restraint and access enhancement, are inherently in conflict. Those same private sector employers must also acknowledge that it has been their basic design of insurance benefits that has generated the perverse economic incentives dominating the reimbursement system today. Since the public sector insurance programs followed the private sector model, government cannot be blamed for this aspect of the overall problem. It is also true that the private sector payers have, at least until very recently, not acted s prudent buyers.

However, the fact remains that most of the cost restraint with which regulation may be credited can also be viewed as cost shifting to the private sector payers who have been lax in demanding a comparable degree of accountability. Moreover, they lack the authority that emanates from the government in the case of regulatory efforts. Oddly enough individual state employee benefit plans have borne just as much cost shifting as private sector plans. In fact, some state policies that reduce Medicaid reimbursement bring about a predictable response from hospitals to increase charges to private payers, like state employee plans

A final introductory word: It is the premise of private sector cost management itself, that the payers have the responsibility to design incentives that will force the providers of services within the limitations of their professional responsibility, to please the payers rather than the regulators or intermediaries. Not only is this consistent with the basic tenants of buyer/seller relationships, it is also the only way that the medical system will ultimately reach an acceptable compromise between demand and need, between access and cost anagement, between quantity and quality.

II. FORCES FOR AND AGAINST CHANGE:

As payers, the private sector employers and the government have identical cost management objectives and face many of the same forces for and against change. This paper concentrates on the next decade. Unfortunately, the primary driving forces that govern both the demand and supply sides of health economics lead one to the conclusion that a goal of significant cost management will be extremely difficult to achieve. Or, to put it differently, cost increases will only be modified if certain conditions prevail and certain values are accepted. These conditions and values include:

1 Changes, whether voluntary or regulatory, must involve all payers public and private.

2. A massive educational effort must be sustained that makes:

-- consumers more aware of their own responsibility for their health, and for acting as prudent buyers/utilizers of medical care and its insurance;

-- the large private and public institutional buyers responsible for benefit design and accountability systems that give them the ability to manage their health care resource expenditures with the same degree of scrutiny that they would apply to any other purchase for which both quality and quantity are important; and

-- all types of providers aware of the economic consequences and alternatives available within the range of each decision they make and each order they approve or initiate.

3. We demonstrate a national commitment to health that is at least on a par with our historical, and very successful, commitment to the best in medical care. Prevention, or wellness, is neither a fad nor the enemy of medicine: it is the embodiment of old and new knowledge combined with the medical and economic imperatives that so clearly show significant health status being dependent upon lifestyle and the preservation of sufficient revenues to meet the true need for acute care being dependent upon preventing otherwise unnecessary demand.

4. Our medical care delivery system will always involve some rationing that, while economic in nature, is inherently a question of ethics and values.

5. Cost management must involve strategies that encompass the troika of health care economics: utilization, capacity, and reimbursement.

Economic Influences

In order to appreciate the limits to cost management opportunities, an understanding of major economic forces must be underscored to make priority decisions among those opportunities, and to develop the system-wide changes that so many health policy experts feel are essential for lasting progress.

1. Costs and demand will increase throughout the 1980s.

   a. The aging of the population will place an unavoidable pressure on demand.

      * those over 65 use twice the health services as those under 65
      * those over 80 use twice that of those between 65-80
      * the fastest growing population group is those over 84

   b. Medical technology is both labor and capital intensive, and increases demand for services by increasing our capacity to respond to what was previously "untreatable." Examples include new drugs, spin-offs from the space program, re-generation, genetic engineering, implantation and perhaps most important of all, telecommunications developments that will dramatically change the delivery system.

   c. One of the unique features of health economics is the reverse correlation between quantity of providers and price/volume increases. Normally, the more providers, the more competition, with a concomitant reduction in price. In the case of physician supply, the opposite has been true. The supply of physicians is growing much faster than even the most conservative estimates of need. The supply will increase by 50 percent by the year 2000. Physician charges are increasing 16-18 percent and nearly doubling every four and a half years. All-payer, hospital rate regulation has no impact on the services provided in physician's offices or on the physician fees charged in hospital settings.

d. Environmental factors that increase health hazards, both known and suspected, are sure to be a major demand-inducing influence during the coming years. Just the uncertainty and fear the public associates with such problems as nuclear and toxic waste, acid rain, and the paucity of adequate water supplies that are safe for human consumption will pose major psychological stresses on communities.

2. Reductions and Increases: A Shift in Responsibility and Burden

a. Though some payers are reducing their unit prices, freezing their outlays, or cutting back benefits, the nation's health care expenses and health care as a percent of GNP continue to soar: $355 billion, 10.7 percent of GNP in 1983.

b. Medicaid is being reduced by the states. This is compounded by "reforms" proposed by the Reagan Administration. Rationing plans based on income, length-of-stay and other criteria are resulting in decreased services and increased cost shifting to private sector payers and private-insured public employee plans.

c. Medicare recipients spend as much out-of-pocket now as they did before the inception of the program in 1965. Furthermore, the Medicare Trust Fund will amass a deficit growing to $56 billion by 1995...and this is the lowest estimate!

d. Private sector payers are revolting over cost shifting and increases that appear unrelated to improve health, benefits or even increased numbers of persons covered. Their actions, if successful, will result in a reduced rate of cost escalation and even greater pressure on counties and public hospitals: the payers and institutions of last resort.

e. Finally, all efforts can only be successful if some providers receive less than would have otherwise been the case. This simple fact guarantees and legitimizes a degree of adversarial relationships at the local level between those who have had control and those who are starting to exercise economic pressure to gain control.

The picture painted above, while not encouraging, gives a reflection of the severity of the problem that should be more than enough to make any public sector payer or regulatory entity welcome the opportunity to emulate private sector initiatives that hold promise for even marginal success in managing health costs. As a practical matter, neither the public nor private sector payers have any economic choice other than the pursuit of effective cost management. Their success will depend to a considerable degree upon their ability to share and cooperate.

III.COST MANAGEMENT OPTIONS

A. State Employee Benefit Plans

There are many efficacious innovations that can be employed to moderate the growth in the state employee health benefit programs and consequently alleviate budgetary pressures on the governor's office. Seventeen states have become self-funded in order to save on premium, administration costs, control the benefits of immediate cash flow, eliminate locking up state dollars in reserves, avoid premium taxes, and maximize on investments from plan reserves. Louisiana, which is self-administered as well as self-funded, cut administrative costs for its state employee plan from nine percent to 4.2 percent in 1982.

In June of 1983, the state of Nevada undertoook a three-pronged cost containment effort which included pre-admission review, concurrent review and the offering of a discounted PPO to the states 14,000 employees and their dependents.

Based on data from the last quarter of 1983, Alfred W. Stoess, chairman of Nevada's Committee on Group Insurance for state employees, attested to significant savings through all three cost management strategies. Savings were most outstanding from concurrent review, accounting for 267 hospital days saved or $213,890. The pre-admission review program saved 212 hospital days or $158,200 and the discounted PPO rates saved $110,947.

The employees and dependents who elected the PPO may choose among three hospitals, two surgical centers and their attending physicians. The hospitals offer discounts of 10, 11 and 13 percent.

Instances were discovered where use of the PPO did not save money for the state or the employees as, for example, in the case where an employee in a rural area drives all the way into the city to a PPO. He is paying more money and the state is paying more money because city hospitals are more expensive than rural hospitals. To prevent this, Nevada dropped its $100 deductible for hospitals outside a 50-mile radius of the PPO facilities.

Combined savings for the three programs are estimated to be nearly .2 million annually.

The state of Illinois has manifested impressive cost savings for its state employee benefit plans since implementing significant changes in 1981. Though it is not possible to attribute the savings to any one change, the list of alterations are provided and each is given credit for the improved cost management achievement. In plan design, the 117,500 state employees now pay a deductible for major medical ($100), each hospital stay ($100), and each emergency room visit ($50). A $1000 stop-loss has been instituted along with a mandatory outpatient surgery list of 67 procedures. If a state employee elects to have one of the 67 surgeries performed in the hospital setting, that employee will pay the entire hospital bill. Since 1981, the number of mandated outpatient procedures performed in the hospital has declined 61 percent. The benefit design alone has made the employees more fiscally responsible for the care rendered. The premium rate increase has moderated considerably: 1981 - 28%, 1982 - 14.4%, 1983 - 26.5%, 1984 - 12.6%, 1985 (projected) - 2.6%. Added to the effectiveness of the overall health cost management program has been the use of non-acute profile for utilization review. The Central Illinois Physician Review Organization identified 23.1 percent of the days provided to state employees in 1981 as non-acute days; i.e., inpatient days in which the patient did not need hospitalization. Through the utilization review program, the percentage of unnecessary inpatient days dropped to 15.2 percent in 1982 P 7 percent in 1983, and 4 percent in 1984, yielding considerable savings to the state.

In Wisconsin, a different strategy provided significant incentives for state employees to alter their plan use leading to a five percent increase in health benefit costs as compared to a projected 17 percent for 1983. The state simply set its contribution to the state employee health insurance at the level of the lowest priced HMO premium offered. Enrollment in HMOs skyrocketed from 15 percent to 66 percent due to the change. The fixed contribution strategy has been adopted by 22 state employee benefit plans.

B. Comprehensive Reform - Education

With no reduction in health benefits, a utilization review program that at best was breaking even, and with the only HMO in the area of the corporate headquarters proving to be more expensive than the company's indemnity plan, Weyerhaeuser was able to reduce health care costs in 1982/83 by approximately 20 percent. The explanation quite simply is employee education and involvement.

Weyerhaeuser's health care costs in 1982 rose 19 percent. After educational plan implementation, the total health care costs in 1983 declined by 1 percent. That trend has continued into the 1st quarter of 1984 with an approximately 1/2 percent drop over 1983 year-to-date costs.

In the face of escalating health care costs, Weyerhaeuser's initial intention was to reduce employee benefits to all salaried employees in 1983. But senior management decided that employees should be given a final opportunity at reducing costs. The message from the CEO was simple, contain costs or benefits will be reduced. The employees, with substantial educational resources provided by the company, responded in exemplary fashion.

The potency of the educational effort was contrasted by two other groups of Weyerhaeuser beneficiaries, who in effect acted as a control group. No reduction in health care benefits was planned and no employee education programs were targeted for retirees or for hourly employees. Not surprisingly, their health care costs continued to rise at the rate of 20 percent per year.

From the company's standpoint, the plan followed a three-pronged attack: effective administration and benefit redesign (as opposed to reduction); organized consumer involvement; and individual employee education and involvement.

Although education is considered to be the major reason for the moderation in health care costs, other strategies were also part of the reform. An incentive program for claims processers, a patient-bill audit program, voluntary second opinions, preadmission testing, 100 percent coverage for outpatient surgery and generic drug purchasing were all included in Weyerhaeuser's efforts. No estimated savings exist for the individual components. But benefit experts within the corporation attribute the major success in cost to employee education.

Weyerhaeuser undertook worksite employee education programs, encouraged local participation in health care coalitions, established employee committees to approach local hospitals about rising health care costs (with a spirit of cooperation not antagonism), marketed personal nsumer education; and set up utilization review by employee committees targeting local problem areas.

Combined with the second opinion, pre-admission testing, and outpatient surgery incentives; the investment in education has lowered every category of utilization, except, of course, outpatient surgery. Even inpatient surgical volume under full, first dollar coverage has dropped significantly, offset by a corresponding increase in outpatient surgery. This fact underscores the value of educating employees about the attending risks associated with admission to a hospital. Since one-third of all iatrogenic disease results from surgical episodes, it is in the patient's best interests to avoid those additional risks.

Some concern about a potential "backlog of utilization" has been expressed by pessimists, but as yet nothing has been noted. The employees seem to have become more invested in their utilization patterns. Moreover, the connection between rising health care costs and moderated salary raises has been stressed by management. Weyerhaeuser salaried employees are acknowledging to the company, in no uncertain terms, that they would rather receive additional dollars in their paychecks than in their benefit payments.

C. Comprehensive Reform - Benefit Redesign

Benefit changes designed to trim $10 million annually from health care costs began last February at Bethlehem Steel Corporation in Bethlehem, Pennsylvania.

Approximately 15,000 salaried, non-union workers and 19,000 retired workers are affected. The basic thrust of the program is a shift from first dollar coverage for basic hospitalization expenses to a comprehensive plan with additional cost sharing, plus a flexible spending account. (See page)

Prior to the establishment of the new plan, employees contributed nothing toward health insurance premiums for themselves or for their dependents. They received first dollar hospitalization coverage and paid a $150 individual/$300 family deductible for major medical expenses.

Under the new plan the company continues to pay the entire premium for the workers, but the worker now must pay $7/month for a spouse, and $7/month for each dependent child. Workers must pay a $356 deductible per hospital admission, $178 per admission to a non-hospital facility, and a $50 deductible per emergency room visit. For all other medical expenses, like surgery and office visits, workers must pay a $300 deductible.

After these deductibles are satisfied the workers are reimbursed 80 percent of the remaining cost, with a stop-loss cap of $1,000 annually.

Other cost saving incentives that have been built into the plan include:

- mandatory second surgical opinion for elective surgery. If a second opinion is not obtained, an employee who proceeds with the surgery must pay 30 percent of the surgeon's fee with no stop-loss cap; and

- a pre-certification requirement for hospital admissions. Based upon a review of the pre-certification findings, a determination is made about the necessity of the procedure and the approved length of stay. Notwithstanding surgical complications or some emergency-only approved procedures. An employee who does not obtain pre-admission certification must pay 30 percent in coinsurance plus a deductible - or 50 percent of the total bill.

The change affecting the status of coverage for retirees has been held up by litigation. A lower court ruled the retiree plan inviolable. Appeals have been pursued, but no resolution of the dispute has occurred.

For companies in the private sector, it is difficult to parcel out the savings that have been garnered by specific cost management strategies, simply because they are rarely introduced in isolation. Rather they usually are implemented as one of a host of alternatives.

In response to 25 percent plus annual increases in health care costs, Plantronics, Inc. of California redesigned its medical and dental plans in 1982 and in one year reduced claims costs for its 1500 employees by 13 percent, an average drop of $168 per employee. The redesign shifted the deductible from outpatient to inpatient care; promoted the idea of good consumer behavior through plan design and corporation communications; placed the employee at risk by linking dependent contributions to performance of the plan; and put the provider community on notice that the company intended to manage costs. The specific numbers involved in the plan redesign are shown in Table 1.

Table 1

Plantronics Medical Plan Changes

	Old	New
Outpatient	80% after ded	100% no ded up to $1000
Pre-admission lab and X-ray	80% after ded	100% no ded up to $1000
in-house lab	100% first $5000	80% after $100 ded
X-ray (included in hosp confinement)	100% first $5000	80% after 100% ded
Hospital confinement	100% first $5000	80% up to $2000 then 100%
Accident	100% first $5000	$100 first $1000
Max out-of-pocket	$500 (of reasonable & customary expenses)	$500 (of reasonable & customary expenses)

An additional $100,000 was saved by adding a 90-day waiting period for the dental plan and for the partially contributory long-term disability program. The old LTD premiums were $1.30/$100. After introducing waiting periods, monitoring disabilities, and putting the plan out for bid, premium costs have been reduced to $0.71/$100.

Although plan design was a major factor in reducing costs, Plantronics felt that its success would have been unlikely without intense communication efforts and the cooperation of the employees.

Preventive medicine and wellness programs have also been inaugurated at some locations, with individual personnel managers, designing their own programs and tailoring outpatient benefits to existing resources. Plantronics pays half of the employee's cost for any outside fitness or wellness programs.

The following companies also boast effective intervention techniques, with overall system savings quantified:

- SCM moved from first dollar coverage to a $150 deductible with 80/20 copayments and second surgical opinions that are projected to save the company $800,000 by 1987.

- Honeywell projects savings of $53 million by 1993 through increased HMO enrollment, aggressive utilization review, and a sound worksite wellness program.

- Reliance Electric reduced medical care costs for its 30,000 employees by $4 million in 1982 through a comprehensive cost management program that includes preadmission testing, mandatory second opinions, hospital bill auditing, and full coverage for ambulatory surgery.

- Hanes Hosiery experienced a four percent increase in its total health care costs in Winston Salem, North Carolina after implementing incentives for using generic drugs, outpatient surgery and testing, and second opinions. A preferred provider organization also accounted for a 17 percent reduction in hospital length of stay for employees. The company had experienced 30 percent annual increases for the three years preceding the changes.

- Rockwell International's benefit redesign is expected to save the company 12 percent on its plan costs. Included in the reformulated plan are cost sharing exemptions for pre-admission testing, birthing clinic services, ambulatory surgery, and second opinions.

A comprehensive approach, as stated in both the introduction and conclusion, has the greatest potential for an impact on health care cost escalation. This requires the private sector moulding its strategies to public mandates. It requires internal coordination amongst the different entities in the public sector - the state insurance department, Medicaid program, state employees benefit plan, hospital rate setting authority, department of public health, state legislature, state and health planning department, and governor's office. And, it requires a concerted effort regarding education, benefit redesign, provider reform, free-market encouragement, well designed regulations, effective utilization review, and a reduction of excess capacity and diffusion of unneeded new technologies.

D. Claims Administration and Management

In analyzing comprehensive cost-management programs, one corporation's efforts to quantify results outshines its peers. Ryder Systems in Miami, Florida has a multi-facted approach to rising health care costs. As a self-insured company, it relies on inhouse claims administration. By scrutinizing bills and by encouraging employees to do the same, Ryder has uncovered significant double billing or unjustified billing. Ryder's claims administration has been particularly effective in monitoring charges that exceed its provider fee structure.

Limitations were implemented on the physician charge after a first visit. The limitation of $60 led to disallowance of $30,000 in charges. $20,000 was disallowed by Ryder when it enforced a maximum $25 payment for chiropractic care. The billing for services provided by assistant surgeons was determined reimbursable only if a medical necessity status was justified, leading to disallowance of $4132 on 95 claims. Outpatient psychiatric visits were limited to $80 per visit leading to the recapture of $20,000 on 1600 excess claims. Finally, surgical visits were scrutinized and 15.9 percent of claims were denied resulting in a savings of $177,000. So far in 1984, the claims administration program has yielded $255,000 in savings on approximately 24,000 claims.

Table 2

BENEFIT REVISIONS

for
Ryder Systems, Inc.

	Charges	Amount Disallowed	Percent Disallowed	Number of Claims Received
Assistant Surgeon (Exceeds 25% of surgeon's fee)	$ 31,197.23	$ 4,132.84	13.2%	95
Chiropractor (Over $25/visit)	150,568.05	22,436.26	14.9	3,477
Secondary Doctor's Office Visits (Over $60/visit)	468,018.36	30,453.47	6.5	15,799
Psychiatric Visits (Over $80/visit)	150,388.55	20,431.00	13.6	1,630
Surgery (Over reasonable & customary)	1,118,113.69	177,608.47	15.9	2,748
Totals:	$ 1,918,285.88	$ 255,062.04	13.3%	23,799

Ryder System's computerized claims processing system (ClaimFacts), considered one of the finest in industry, saved the corporation over $ .2 million in medical charges in 1983. Cost control efforts of claims processors accounted for additional savings of nearly $1.8 million last year, resulting in total health care savings of $2.9 million for 1983.

Table 3

Savings

Coordination of Benefits	$ 1,251,622
Charges not covered (aspirin, vitamins, etc.)	169,863
Vehicular exclusions	147,479
Consultants and Audits	132,437
Hospital personal items not covered (TV, telephone, etc.)	41,805
Exceed semi-private room	39,403
Duplicate bills	1,006,841
Ineligible participants (terminated employees, etc.)	68,880
Surgical charges (exceed reasonable and customary)	45,538
Total	$ 2,903,868

The ClaimFacts system "red flags" ineligible participants, any non-compliance with the second surgical opinion requirement, and duplicate bills -- the new system caught almost 2,000 duplicate claim submissions that likely would have resulted in a second payment under Ryder's previous manual processing system.

Claims processors are responsible for monitoring various plan provisions, coordinating benefits with other group insurance, and referring questionable or excessive charges to consultants.

Based on the number of claims paid per department employee the benefit department's productivity has increased by 130 percent since 1981, when claims were processed manually. The benefit department has enjoyed the increase in productivity without an increase in staff for the past four years, despite a 20 percent growth in claims volume over the same period.

In addition, the administrative costs in the benefits division -- with 30 employees, the largest administrative division in the company -- were reduced by 14.6 percent last year.

ClaimFacts provides the type of detailed breakdown of benefits utilization that an increasing number of benefits managers find invaluable in modifying their companies health plans. It affords instant access to spending and cost information broken down by doctor, hospital, diagnosis, and by region of the country, state, local and even by zip code.

To facilitate employee involvement, Ryder implemented a hotline to answer inquiries from its work force, dependents, and retirees. In attempting to gauge the response of employees to the program, Ryder discovered that its "Take Care" hotline received 25,000 calls last year. Due to an effective employee education program that delineated the nature of the nation's health care cost problem and its impact at Ryder, employees have overwhelmingly supported the company's efforts to arrest health care cost escalation.

To bolster its employee education effort, Ryder implemented a two-fold bill audit program that saves three dollars for every dollar spent. Employees are entitled to 25 percent of the difference between the erroneous charge and the appropriate hospital charge, up to a maximum of $500. In the first six months of 1984, 41 bills were amended saving Ryder $15,000. Another $15,000 has been collected in the same period of time through a contracted audit program that leads to review of any claims exceeding $10,000. In each program, providers have responded with concern about the errors. The sense of alarm exhibited underscores the value of the "sentinel effect" putting hospitals and physicians on alert regarding the possible monitoring of their billing practices.

Denny's Inc., a La Mirada, California based restaurant chain, says it is saving almost $1 million a year by using in-house computer terminals to self-administer the medical, dental and disability claims of about 26,000 employees.

Denny's computerized claims processing system with 25 terminals and 11 claims employees, processed about 123,000 claims last year. Under the old manual claims processing system, the average cost to process a claim was $10 to $18. The computerized system costs Denny's approximately $5 per claim to process.

E. CAFETERIA BENEFIT PLANS

As many as three hundred companies have introduced cafeteria plans in order to better accommodate the individual needs of employees in a changing work climate. Countless permutations of the benefit plan offered by the employer lead to a more flexible act of options. Such variety introduced simultaneously has resulted in health care cost savings, but in most cases it is impossible to quantify these savings. Nevertheless, several companies have published overall savings figures that demonstrate that the concept may be one worth endorsing.

Morgan Guaranty currently provides its employees with one of the best and most costly (43% of payroll) benefit programs offered by any major corporation. For the last several years, medical plan costs had been rising at a substantial rate. Morgan's response to the incremental rise in its medical plan expense was the introduction of a cafeteria benefits plan called "Flexcomp." The five reasons for designing a flexible compensation program were:

- to retard the rate of increase in the medical plan expense;
- to offer a dental plan, in which employees would share heavily in the cost;
- to utilize employees' pre-tax dollars to fund benefit plan contributions, which would also make cost increases in the employee portion of existing benefits more acceptable;

- o to offer new specialized benefits, without increasing Morgan's benefits expense; and
- o to permit a higher level of pre-tax deferrals to the profit-sharing plan.

Due to concern about communicating this complex program to the employees, Morgan decided to introduce the program in three phases.

For Phase 1, three medical plans, plus the HMO option were offered. The three plans (A, B, and C) differed only in the amount and type of deductible, and the monthly cost to the employee.

To make the lower-priced premium with higher deductibles less financially risky and more appealing to employees, Morgan permitted salary reduction up to $1000/year, to be deposited into a health care spending account. Claims for health care expenses, which would not have been reimbursed by an individual's medical and dental plans would then be reimbursed with the pre-tax dollars that had been set aside. Any money remaining in this account at the year's end would either be recovered as taxable cash or deferred into the company's profit-sharing plan, at the employee's election.

In Phase II, the employees were permitted to reduce their salaries by up to $1000, to be deposited in their profit-sharing accounts. This will benefit employees who are looking for additional tax-deferred savings opportunities to supplement their retirement incomes.

In January of 1985, Phase III will be enacted, with the major enhancement to the FlexComp Program being the addition of a dependent care account, to be funded through salary reduction.

Morgan believes that the pricing of its medical options -- Plans A, B, and C -- will be the key to eventual savings. In the first year of the plan, the difference between the least expensive and the most expensive options were a modest $165 a year per family. This small difference provides little incentive to "trade down."

In the second year of the plan (1985) repricing based on 1984 experience, will increase the price of plan A by, approximately 12 percent while the price of plan B will increase only 8 percent. In 785, it is expected that more employees will elect Plan B or C because of the differential in premium price. Over several years, then, more and more employees will give up their high-cost coverage and accept higher deductibles. The company anticipates reduced hospital admissions through the economic influence of the increased cost sharing.

Additionally, Morgan will change its practice of contributing equally for the medical coverage of its employees. Now Morgan will contribute only the value of the lowest priced plan. It will contribute the same dollar amount for each employee regardless of which plan is selected -- the employee who wants to remain in Plans A and B will pay the additional premium costs.

E-Systems, Inc., a Dallas-based high technology electronics firm, estimates savings on its medical plan of $2 million a year with the stitution of a flexible benefits program -- the Special Employee Expense Account (SEEA).

Despite the uncertainty of future legislation, E-Systems was convinced of the advantages of moving ahead with flexible compensation largely by the dramatically changing demographics of the company. For a firm with young adults, single parents with dependents, older employees, and two-worker families, no one benefit plan meets the needs of its workforce. The new plan appeals to each employee for a different reason, and has been well received.

The core of the benefit plan is a flexible spending account. Pre-tax dollars go into the plan from four sources: savings from selecting a less comprehensive health plan, savings from a less expensive life insurance plan, a trade-off of up to half of the value of vacation days, or salary conversion.

The "flexible dollars" in the account can then be spent on a variety of benefits. All participants must include one of three health care options, the choice is between the present comprehensive plan or two plans with higher deductibles. HMO choices are available in areas that offer them. Other choices of benefits include everything from dental care to prescription drugs, to additional vacation days. Up to $12,500 pre-tax can go into an expense account each year. A participant also has the choice of receiving flex dollars that are not spent for benefits in taxable cash.

A key to the selling of SEEA was an extensive educational program and individual counseling.

According to the corporate director of employee benefits, start-up costs were approximately $350,000 to $400,000 with another $100,000 to $150,000 spent on communications.

In the first year, thirty percent of all employees selected a less xpensive medical plan - resulting in an estimated overall savings of approximately $2 million. Other notable savings from corporate cafeteria plans include:

- Pepsico reported that its employee group experienced a nine percent cost increase in 1982 compared to 18 percent in 1981.
- American Can experienced a compounded rate of increase in its flexible program of 13.1 percent from 1978-82, compared with the corporation's traditional program still employed by union workers with average increases of 20.9 percent for the same time period. More than half of the employees selected the 80 percent

copayment option versus first dollar coverage in order to maximize on the other benefit options.

- The Quaker Company reported a reduction in its overall health cost increase from 20 percent in 1982 to 4 percent in 1983.

Flexible spending and cafeteria benefit programs are presently being studied by the Department of Health and Human Services. The Congress afforded a one-year respite for the plans; though the Department of Treasury has written regulations that would make most of the reputable plans, including the five cited above, illegal. Congressional action in the next year will determine the future of these kind of work force arrangements.

The noteworthy aspect of cafeteria plans is the savings that accrue when benefits are more individually tailored to meet the needs of a diverse work force. Though the entire concept of "spreading risk" comes into question when assessing the value of cafeteria plans, the feasibility of offering more choice should not be ignored. Furthermore, an equal employer contribution policy clearly establishes a precedent for giving employees or consumers an incentive to select their insurance coverage prudently. Cost-conscious enrollees will be less likely to select exotically - priced coverage if they are expected to pay for the additional and often unnecessary extensive coverage.

F. Financial Incentives

Since 1981, the Berol Corporation has offered an individual incentive plan to its 400 salaried employees at its Danbury, Connecticut headquarters. After the end of the year, Berol pays each modest-using employee the difference between $500 and the amount the employee received in medical benefits. During the first year of the plan, 75 percent of employees received an average taxable, incentive payment of $400. The plan's second year showed a slight drop to 71 percent of employees receiving a payment, but the average increased to $430. Third year plan results remained approximately the same. The "cash back" plan has shown an average 20 percent cost saving per year, over the old plan.

The employee reaction has been extremely favorable with 80 percent rating the plan as better than the previously provided benefits according to a recent employee survey. Thirty to forty percent of employees actually changed their behavior regarding their personal health habits and health care utilization practices. An ongoing, aggressive educational campaign, including an audiovisual presentation and individual face-to-face meetings with each employee, has helped ensure its continued success.

The plan was recently expanded to cover all salaried employees nationally, and an expansion is being planned to cover all hourly employees as well.

SI Handling Systems in Easton, Pennsylvania, has given its union employees a new incentive to restrain use of frivolous health care by tying wage increases to health care cost increases.

A new three-year contract, overwhelmingly approved by local members of the United Steel Workers of America, establishes minimum and maximum wage increases for each of the next three years.

The wage increases work as follows: if the increase in health care costs are less than 10 percent, employees will receive the maximum wage increase. If costs rise between 10 percent and 25 percent, the wage increase will be correlated to that percentage rise, set between the minimum and the maximum. If costs rise by more than 25 percent, employees will receive only the minimum wage increase.

Employees, who make an average of $9.54 an hour, will receive the minimum wage increase of 2.98 percent or 28.43 cents an hour this year. The second year the minimum wage increase is 2.85 percent or 27 cents, and the maximum is 4.08 percent or 40 cents. The third year, the minimum is 2.97 percent or 28 cents, and the maximum is 4.4 percent or 45 cents.

Interest in creating a PPO is also being considered to increase the employees' incentives for moderating their health care utilization.

G. Utilization Review

Utilization review is the process of assessing medical care services to assure quality, medical necessity, and appropriateness in terms of level of care and treatment setting. Estimates of unnecessary inpatient usage range from 15-30 percent of all hospital days, suggesting a great potential for effective utilization review. Medicare review is now being performed by Peer Review Organizations (PROs); private review has fallen to some PROs as well as newly emerging review entities. Review can be provided through a variety of strategies, ranging from pre-admission, concurrent, and retrospective hospital review to quality and bill audits.

During the seven years since institution of its utilization review plan, Deere and Company of Moline, Illinois, has achieved a 38 percent drop in hospital days per thousand Iowa employees and a 34 percent reduction for Illinois employees. Utilization review, in concert with the offering of an HMO, over the last two years has produced an overall reduction of 40 percent in health care usage. Approximately 45 percent of Deere's employees opted for the HMO option, after a heavily publicized in-company promotional campaign.

Caterpillar Tractor Company in Peoria, Illinois, contracted with he Mid-State Foundation for Medical Care -- a peer review organization -- to provide profile analysis of its medical claims. Over a four-year period, Caterpillar reported decreases of 10 percent in admission rates and 8 percent in the average length of stay. These decreases reduced its number of hospital days per thousand employees by one-third, to just wer than 700 in 1983 from more than 1000 in 1978.

Caterpillar, in cooperation with the medical societies of Peoria and two adjacent counties, has subsequently agreed to form a third party committee to enable other companies like Caterpillar that have good, reliable data to come and discuss inefficiency problems they are noting in the local health care delivery system.

The medical societies in turn contact the inefficient providers and discuss their findings. The results of its peer review program have proven so positive that Caterpillar has recently extended it to include nursing home care. And it is presently reviewing ways to apply concurrent review to ancillary services. Other UR successes:

- The Sundstrand Corporation cut its days/1000 from 747 to 552 in the first four years of a retrospective review program implemented in 1978.

- A. O. Smith of Milwaukee diminished its inpatient utilization from 874 to 535 days/1000 in an 18-month period relying solely on retrospective utilization review of hospital cases.

- The St. Louis Area Business Health Coalition has contracted for concurrent utilization review on psychiatric care estimated to yield a savings of $1,614 per admission based on a reduction of 5.38 days per episode.

Utilization review is an essential component of an effective health cost management strategy. It can be performed in the Medicaid and state employees program. Utilization review programs have been proven to produce positive financial and quality results. None need to be done on 100 percent of cases. Pre-certification can be done via the phone with a small nurse team using agreed upon protocol. The past four years have seen the commercialization of an utilization review industry. PROs; the old PSROs; third party administrators like U.S. Administrators from Los geles; computerized profile analysis firms like Health Data Institute, HSI, 2M and Medstat; insurance carriers; and an increasing number of innovative benefits management firms such as U.S. Corporate Health Management offer utilization review programs of varying styles.

There are no major private sector cost management programs which do not include at least some component of utilization review. State governments either for their employees or for public patients, can achieve the same positive results that private sector employers are experiencing.

H. Case Management

The concept of individually managing care, as another form of utilization review, is gaining favor with companies. A concern for freedom of choice is being replaced by a management process that offers greater assurance of quality, appropriateness , and cost efficiency. Corporations perform this kind of management by overseeing the selection of an appropriate setting for costly cases.

- Pratt & Whitney has garnered impressive results from its Medical Information Service which acts as a gatekeeper by informing employees of the most appropriate and cost-efficient setting and provider available for needed services. Through a series of pamphlets, posters, and newsletters, the company has stimulated active use of the program with no adverse employee responses. It has also led to a feedback loop from employees to the company on the overall performance of area physicians and hospitals. The company estimates savings of $175,000 in the first two and a half years, with an additional $75,000 in savings to employees.

- Owens-Illinois, employing a patient services prenotification program and a mandatory second opinion program, reduced hospital inpatient days by 15.7 percent from 788 per thousand employees in 1982 to 664 per thousand employees in 1983. Length of stay in that same period dropped from 6.3 days to 5.9 days, as did admissions/1000 insured employees from 173 to 125. Under the prenotification program the patient must notify Owens-Illinois patient services coordinator if any of a list of 13-16 procedures is recommended. The patient services coordinator discusses various available alternatives, level of reimbursement, asks if the provider offered alternatives, advises what course to follow and where and when to seek second opinions. The penalty for non-notification or for not getting a second opinion is 20 percent of the cost of the procedure. The two programs cover 90,000 salaried workers, hourly employees, dependents, and retirees. Owens-Illinois has found that the service is often used for non-mandatory procedures as a means of patient education.

o Aetna Life Insurance Company saved $3 million on just 60 chronically-ill patients in 1983 through the use of a case management system. This was a 66 percent increase over 1982 -- when $1.8 million was saved on 23 cases. The case-management review process which is handled in-house by Aetna prevents unnecessary hospitalization and shortens the length of stay by providing appropriate alternate treatment settings such as home health care or skilled nursing facilities.

Employers are responsible for communicating the case management concept to their employees. The reaction by both employees and their families has generally been excellent. The strategy has proven so successful that Aetna is investigating the feasibility of extending the case-management system to include less expensive cases that constitute a higher volume of claims.

o Prudential Insurance Company's "Patient Management Program" (PMP) emphasizing home health care, saved the corporation $375,000 in 1983 while being administered only through the Denver and Reno offices. This savings was 63 percent more than the $230,000 saved in 1982.

Under the PMP, a Prudential patient care coordinator visits insured clients in the hospital and discusses coverage with the patient. Alternatives to inpatient treatment are addressed, including home health care or hospice care. Discharge planning with a physician is also explored.

Prudential also conducts preadmission, concurrent, and retrospective reviews; in the final case to determine hospitals with excessive lengths of stay to be targeted for particular scrutiny by the PMP program.

The program's success can be attested to by the planned addition of 20 PMP sites in January 1985. An additional 20 cities will also be studied for future implementation.

Individual case management, though costly in terms of resources has great potential for some individualized cases. In most group insurance plans, a small percent of the group consumes the vast majority of benefit payments.

Screens can be established as a way of identifying or flagging potential high cost episodes. With these in place, timely intervention and patient education may result in the appropriate setting for care rather than the misuse of valuable resources due to the peculiar vagaries of the reimbursement system. Mismanaged care predominantly occurs with chronic care cases. These bear the most potential for cost savings. Long-term disability and workmen's compensation cases also generate potential abusive situations that require case management monitoring. Even selected short term medical cases can benefit. For example, 75-85% of adult hernia operations can be done on an outpatient basis. Not only does this eliminate a 4-6 day hospital stay, it also reduces a 6-8 week disability to less than one week.

I. Second Opinions and Incentives for Outpatient Utilization

The greatest value of second opinion programs is the drastic cutback in unnecessary surgery. Cornell Medical Center's heralded mandatory program saves $2.63 for every dollar spent.

Connecticut General's (CIGNA) second opinion surgery program has shown significant savings each year since its inception. In 1980, the program saved $174,000 and 237 disability weeks on 162 enrollees. In 1981, $330,137 and 400 disability weeks were saved. In the first half of 1984 alone, $731,958 and 709 disability weeks have been saved, on 1,423 enrollees. $8.53 was saved for every dollar spent on health care in 1984. CIGNA feels it is reasonable to assume a 90 to 95 percent utilization rate for the mandatory procedures.

Some of the key accounts summarized in CIGNA's Second Opinion Data Analysis include savings of $20.97 by United Airlines for every dollar spent thus far in 1984, and a year-to-date savings of $103,035; $18.07 saved per dollar spent by MDC; and $19.67 saved per dollar spent on health care by Singer.

o A Southeastern Ohio Blue Shield Plan reported the cancellation of 53 percent of 215 surgeries where a second opinion was received in 1981, an estimated savings of $258,000.

- Seven state Medicaid programs have established mandatory second opinion programs with results confirming a 2:1 return on investment for the additional opinion.

- A mandatory second opinion program in the Massachusetts Medicaid system cut the total volume of surgery by 20 percent in 1982.

As an integral part of its comprehensive major medical program, Tosco Corporation in Los Angeles, California enacted a second surgical opinion program for elective surgery. The company's medical program traditionally had a $100 deductible ($200 per family), 80 percent reimbursement (50 percent for outpatient mental), and an individual stop-loss level of $2000 in expenses ($5000 per family). Under the cond surgical opinion program, however, surgical fees for all elective surgery performed in a doctor's office, an ambulatory surgical center, or the outpatient department of a hospital will be covered at the rate of 100 percent -- if confirmed by a second opinion. The plan even enables an employee to seek a third opinion at no cost.

If instead of obtaining the second or third opinion an employee proceeds with surgery on his/her doctor's recommendation only, all expenses incurred will be treated as major medical expenses, with a 20 percent employee coinsurance.

Major cost savings generated by surgi-centers in general result

Major cost savings generated by surgi-centers in general result largely from the elimination of medical frills. In contrast to a hospital, surgicenters as a rule:

(a) use fewer lab tests;

(b) utilize fewer employees because no night shift is required. (but have a higher patient/nurse ratio - about 1.5 to 1); and

(c) generate fewer overhead charges because there is no employee cafeteria, laundry, full-time lab technician, full-time x-ray department, or full-time pathologist.

Each procedure involves one all-inclusive fee. Much like hospitals, quality of care is monitored by a peer review committee. Mortality rates are also considerably below those recorded in hospitals.

Comparison studies have substantiated these conclusions. A 1977 study released by HCFA found that costs for the same procedures done in a surgi-center cost 55 percent less than if they were done in a hospital, and cost 15 percent less than if they were done in a hospital outpatient facility. It also noted that quality of care was as good as other surgical facilities in the area.

- The South Florida Health Action Coalition estimates that businesses in the Miami area could have saved $300,000 on 776 cases in 1981 if the patients had used the available outpatient facilities for their surgeries.

- A regulation that required District of Columbia physicians to perform 48 common surgeries in the outpatient setting saved Medicare and Medicaid $600,000 in 1979 or $319 per procedure.

- A number of coalitions and employers have insisted upon mandatory outpatient surgery for a list of 13-300 procedures.

- Blue Cross and Blue Shield plans of Minnesota, North Carolina, and Kentucky estimate savings of 57-78 percent through extensive use of outpatient settings for 7-63 selected procedures.

J. Hospital Bill Audit

CIGNA's hospital bill audit program has shown significant savings thus far in 1984. As of September 1984, audit costs were $454,088. Improper charges of $1,046,818 were discovered on $47,589,431 total charges audited, for a net savings of $592,730. Savings for the year should be approximately $800,000 with a cost effectiveness ratio of $2.30 saved for every dollar spent.

"Equifacts" the Upholsterers International Union's hospital bill audit program saves the union $3.16 for every dollar spent. In the first seven months of 1984 $19,000 in undocumented charges were discovered from the $365,000 in hospital charges audited by Equifacts. Deducting the $16.80 cost/$1,000 audited resulted in a net savings of roughly $13,000 on 18 patient claims.

o Employee audits yield 25 percent of realized savings up to a maximum of $500, for the Ryder workforce. An average of $210 per case was saved in 1983. The greatest overstatement of hospital charges discovered by an employee was $6,936.

o Pacific Mutual Life Insurance Company reported a $9.51/$1 ratio of savings-per-dollar-invested in its dental review audit program in 1982.

- In 1982, the Louisiana Blue Cross and Blue Shield Association recouped $356,640 after auditing its 767 highest cost claims.

Audit firms of all types report that 50-100 of all large hospital bills contain errors which are very rarely on the side of the patient. Involving the patient has proven to be an effective educational device that makes the real consumer a partner in the cost management effort. This type of program is a very important part of cost management because it is hard to convince patients they pay more, change their life styles, challenge their physicians, accept less convenience, etc., unless the employer is actively policing the abuse on the provider side.

K. Pre-Admission Certification

In 1983, LTV Energy Products made three major changes in its medical care plans. The principal changes were a pre-admission hospital certificate program, an increase in the deductible to one percent of the employee's annual salary, and an extension of the deductible and co-payments to a greater range of medical charges.

Analysis of benefit payments before and after the change, adjusted to constant dollars, indicates an annual savings of $2.3 million. Most of these savings come from the reduction of hospital utilization, estimated at $1.8 million, with no reduction in benefits.

Hospital admissions per 1,000 employees and dependents dropped 31 percent. The average length of stay dropped 7 percent. At the same time, there was practically no change in the average daily hospital charges, expressed in constant dollars. The net effect was a 35 percent reduction in constant-dollar hospital costs per employee.

Hospitalization savings are directly attributable to the new pre-admission certification program. Under this procedure, hospital admissions and the length of stay are approved in advance by the claim administrator, John Hancock Mutual Life Insurance Company with the assistance of the Texas Medical Foundation. The advance approval procedure introduces a "gatekeeper" effect similar to that found in HMOs.

The annual savings for medical benefits other than through hospitalization, amount to $.5 million in constant dollars. This is a 31 percent reduction in cost per employee from the prior medical plan. This savings is the net effect of (1) the direct design savings from increasing the deductible and applying the deductible and co-payments to more expenses; (2) the utilization savings that come from the economic involvement of employees in the cost of medical care; and (3) the shift to outpatient costs from inpatient costs arising out of the advance approval for hospitalization. The impact of these effects separately is not readily determined.

o Chrysler's pre-determination program for podiatry services saved over $1 million in its first year of implementation in 1982.

o Zenith's Medical Services Advisory Program saved the corporation $53,000 in the first quarter of 1983 by screening non-emergency hospital admissions and counseling the use of more cost-effective alternative settings.

o The Public Service Electric and Gas Company of New Jersey reduced average lengths of stay by 3.8 days when laboratory and diagnostic tests were performed prior to admission to a hospital for surgery.

o Motorola saved $23/insured through its pre-admission review program.

- The Missouri Medicaid program imposed prior approval limitations on expenditures for dentures cutting program outlays for those appliances_from $4.1 million in 1981 to $2.1 million in 1982.

L. Preferred Provider Arrangements

Preferred provider arrangements are designed to limit the choice of physicians or hospitals to a group of pre-selected, cost-effective providers. Many have been established by hospitals simply to maintain or increase market share. These arrangements typically rely on unsophisticated discounts off total charges. As has been noted by critics of these designs, a 20 percent reduction from the most costly product may not result in a savings to the purchaser. A new generation of preferred provider arrangements has resulted in employer or insurer-sponsored plans that delineate criteria for participation resulting in the exclusion of inefficient and costly providers.

Cleveland-based Stouffer's Corporation responded to rising health care costs by developing two medical Preferred Provider Organizations (PPOs) -- one hospital-based and one physician-based -- and two dental PPOs. About ten percent of Stouffer's employees have signed up with the two medical PPOs which cover a geographic region encompassing 50 percent of Stouffer's workforce. The hospital-PPO has been effective in reducing health care costs over the short run, as indicated by the monthly costs at the end of 3 and 6 months:

Table 4

Health Care Cost Per Employee	End of 3 Mos.	End of 6 Mos.
Cleve. Area (Avg)	$107.21	$ 96.04
Hospital-based PPO	85.69	74.26
Physician-based PPO	131.28	100.42

The physician-based PPO has also cut its costs but only after a more stringent utilization review program was implemented. A change in the plan's medical director has also resulted in a modification of the practice styles of participating physicians.

The dental PPOs have produced similar savings of 35 percent and 20 percent respectively. Some 24 percent of Stouffer's Cleveland-based workforce has signed up with five dental groups.

Stouffer's feels that the key to a successfull PPO effort is the use of utilization review (retrospective and pre-admission testing in particular) combined with patient and physician education.

Security Pacific Corporation of California implemented a PPO program on September 1, 1983 as an added health care benefit to their 20,000 employees who do not have HMO coverage. The PPO plan requires no deductible and covers 100 percent of the expense for most categories concerned, as opposed to the traditional health care plan which requires a $175 deductible and 80 percent coverage for most procedures. To encourage employees to use the PPO, 100 percent coverage was also added for annual gynecological exams, as well as baby care through the first year, and childhood immunization through two years.

Officials estimate that the PPO will save Security Pacific $805,631 in the first year. This estimate uses a conservative utilization rate that 40 percent of the employees will use PPO physicians. Savings could be considerably higher as the utilization rate in other corporations has averaged 50-55 percent.

Table 5

The reductions in payments, based on the fee/visit are:

Hospitalization	10%
Surgery	30%
Maternity	25%
Office visits	30%
Physician visits (hosp)	14%
Outpatient hosp.	5%
Diagnositc X-ray + lab	15%

Additional 5 - 10 percent savings are considered likely, due to use of primary care settings, generic drugs, second opinions, and pre-authorization.

The Automobile Club of Southern California contracted with a preferred provider organization early this year after utilization data from its claims- handling computer showed such a move would be cost-effective. The Auto Club initially considered raising its deductibles in response to rising health care costs, but data generated by the computerized claims systems advised against implementing such a change, showing savings would be insignificant. But, an analysis of money spent on recent hospital stays, surgeries, and outpatient treatments helped the club identify substantial savings if its employees were treated through a PPO.

Employee contributions remain the same with the PPO: a $100 annual deductible/employee, $200 annual deductible/dependent and 10 percent copayments up to $5000. But, to encourage employees to use the PPO, they will only have to pay a maximum of $5 per office visit if using PPO-affiliated doctors. This change in addition to a slight change in the prescription drug program--adding a maximum $2 payment per prescription--is conservatively estimated to save the Auto Club five to ten percent of its health care costs in the first year of use.

Hewlett-Packard Company in Palo Alto, California, by putting together its own preferred provider organization (PPO) expects savings of anywhere from $200,000 to $700,000 in 1984. H-P's desire for accurate comprehensive data on health care providers was a primary motive behind the formation of its PPO. Preferred providers are chosen on the basis of lower hospital per diem rates and reasonable lengths of stay not through discounts.

By analyzing charge data, H-P has identified and contracted with a preferred hospital which is approximately two hundred dollars a day less than the community average. Two hundred seventy preferred physicians have also been selected.

All treatment will be reviewed by El Camino Preferred Physicians Utilization Review. U.S. Administrators, Inc., in turn will audit El Camino's review procedures.

Approximately 8,500 H-P employees are potentially interested in the PPO. Based on these numbers, a savings of $200,000-$700,000 is expected this year. Employees will be given an economic incentive to use the preferred provider through reduced cost sharing. The company will pay 90 percent of PPO charges compared with 85 percent under its traditional plan.

o The American Family Corporation in Columbus, Georgia, is marketing a PPO to its employees that places critical emphasis on physician selection as opposed to discounts. The company's medical director has selected the 102 physicians who, as a group, averaged $1,809.45/admission in 1982 (compared to non-participating peers cost of $2,614.48).

o Metropolitan Life Insurance Company's "Met-Elect" PPO for the Dade County School Board's 16,331 employees saved $500,000 in the first six months of operation in 1984. Hospital admissions have dropped 14.8 percent and average length of stay fell 14.5 percent. Pre-admission testing skyrocketed 327.8 percent, use of freestanding surgery centers climbed 138.5 percent and outpatient surgery in general rose 47.1 percent.

Mandating disclosure of prices or even a comprehensive state medica data commission would lay the groundwork for a flourishing competitive ket place in which PPOs would be a focal point. The very essence of PPOs assumes an opportunity for enrollees to shop for health care. If no enlightening data exists from which consumers can make prudent decisions, then PPOs will not proliferate. By establishing a state data commission that collects and disseminates provider-specific price, utilization and quality information. States make a major contribution to more cost-conscious consumers and eventually a moderation in health care costs.

M. Health Maintenance Organizations

A study completed in June by the Rand Corporation demonstrated a 40 percent less hospital costs and an overall 25 percent savings in health costs for an HMO compared to indemnity coverage in the Puget Sound area of Washington. These facts are one of the major reasons behind the burgeoning growth of HMOs. By the end of 1983, 290 HMOs nationwide had enrolled 13.6 million Americans up 15 percent from 1982. By all accounts, these enrollment figures are expected to continue to surge.

A number of private and public sector employers have attributed health cost savings to increased HMO enrollment in their work-force.

- United Technologies estimated a savings of $200,000 for last year when 1000 employees switched to indemnity coverage raising the company's HMO penetration to five percent.

- Ford Motor Company quantified savings of $5 million in 1982 from the 8.5 percent of its workforce that have opted for the less costly HMO premiums available to them.

- The 28 HMOs offered by FMC Corporation have yielded $1 million in cost savings for the company.

- W. R. Grace estimated savings of 11 percent of total costs based on the company's 13 percent HMO penetration. Grace offers 23 HMOs to its 62,000 workforce.

- New York Telephone saved a half a million dollars in 1983 due to its 20 percent increase in HMO enrollment, now at 12.3 percent of the entire workforce.

N. On-Site Medical Facilities

Employers can have a dramatic impact on their health care costs simply by expanding the services they provide at the worksite. Since medical staff are generally salaried employees, the entire incentive structure for use and abuse of the facilities change, as compared to the fee-for-service sector.

Gillette uses its in-house medical facilities and staff to provide direct care to its employees in Andover, Massachusettes; St. Paul, Minnesota; and Boston. For 1983, the cost of operating the Boston facility was approximately $1 million with savings of $1.4 million.

The plan is described as "essentially an HMO" with an emphasis on primary care. The facilities provide complete opthamologic services including contact lenses and eyeglasses. Ninety percent of employees use the Boston facilities, amounting to 39,000 visits/year. Consistently low rates of hospital admissions and length of stay have been sustained. Total hospital days per 1000 employees were, 551/1000 in 1982, 571/1000 in 1981 and 532/1000 in 1980. Gillette's inhouse clinics have proven to be an important factor in increased employee morale.

New York Telephone's in-house medical department is a model corporate program. Through a management program that encourages intervention in preventive and rehabilitative medicine, NYT physicians actively interact with the company's burgeoning workforce. Estimated savings in its hypertension screening and treatment program are $663,000 with $1.5 million saved from its alcohol control program, $302,000 from its well-back program, $268,000 from its stress management program, and $269,000 saved from its breast screening program.

An alcohol/drug abuse day program recently introduced by Boston-based New England Telephone Company as part of its Employee Assistance Program (EAP) will save the company an estimated $560,000 in rehabilitation costs on the 100 people projected to use the program this year.

The substance abuse day program runs eight hours a day, 5 days a week for 2 weeks and is offered to all of the company's 30,000 employees. It encompasses educational lectures, group and individual counseling, exposure to a self-help group, and family involvement.

The alternative to the day program is a 4-week hospital rehabilitation program, which costs the company $5,300/employee plus an estimated $2,000 in lost time and wages. The day program on the other hand costs $698 per employee plus $1,000 in lost wages. This amounts to a savings of $5,602 per employee, or a total of $560,200 for the 100 who e projected to use it this year. Forty-six have completed the program in the first half of the year.

New England Telephone's program is unique because it is the only one conducted in company facilities in the country. This feature increases cost efficiency and convenience. In establishing the program during 1983, the company measured a recidivism at 18 percent which is considerably below national norms for alcoholism rehabilitation.

Applying the notion of cost savings to mental health can be somewhat confusing. Often times, the more conscientious EAPs generate higher numbers of psychiatric referrals thus raising a company's overall health care costs. However, a successful intervention does yield more productive employees by nipping problems like alcoholism and depression at an early stage and thus moderating medical treatment costs. Scrutiny of program design is necessary to optimize savings.

Continental Bank's program, for example, ensures the necessity of referral treatment by offering second opinions. In cases where a family doctor has recommended a psychiatrist, its EAP counselor may suggest another more cost-effective and appropriate form of treatment. In some cases, a self-help group can act in lieu of professional help or an employee can receive help from a mental health center charging a fraction of the cost for psychiatric care.

The Continental EAP also concludes case follow-ups, determines effectiveness of treatment, and monitors rehabilitation programs for psychiatric illnesses.

These example underscores the critical value of providing cost-effective primary care. Virtually, any strategies that promote primary care services, if well-managed, should yield cost savings.

D. Generic Drugs

The Health Insurance Association of America estimates that as much as 60 percent of overall drug costs can be recouped through an effective generic drug substitution program. Empowering pharmacists to be able to act independently of physician orders is one way to facilitate greater reliance on generic drugs.

Rockwell International's worksite pharmacy in Iowa saves $1,400 daily filling 96 percent of its employees' prescription drug needs.

Thrift Drug prescriptions-by-mail program with generic substitition, saves Pennsylvania (the state as employer) $2 per prescription, based on an average order of 64-65 days of medicine. The savings would be doubled if participants ordered the full 90-day supply.

There is no deductible and no cost to the employee for use of this program. Both brand name and generic drugs are offered, with the purchase of generics being encouraged. Elimination of the brand name offering would result in further savings. At present 2000 claims/month are processed. However, with 60,000 union and non-union members plus an additional 130,000 dependents able to participate, utilization is far below potential. Reconfiguration of the program, employee education, and better advertising would prove advantageous.

In 1983, Uniroyal's 10-year old prescription drug mail order program saved the company $6.50 on each generic prescription ordered over a brand name prescription. Savings on brand name medications were in the area of $2/prescription. Currently 35 to 40 percent of all Uniroyal prescriptions dispensed by Prescription Delivery Systems (PDS) are filled using generic drugs.

The primary impetus behind the program was the recognition that Uniroyal's retiree population, especially, could benefit from volume purchasing of generic drugs. Their fixed income and greater need for maintenance medication to treat chronic illnesses gives them more incentive to have prescriptions filled through this program.

Uniroyal also recognized that other provisions needed to be made for active employees who require greater access to prescription drugs for treatment of short-term, acute illnesses, a different type of program was devised for them, involving cost sharing as an incentive to control expenditures.

Additional savings are anticipated in the near future with the expiration of patents of several of the most widely prescribed drugs including Inderal and Valium, which should greatly increase the percent of generic substitution under the program.

Uniroyal has also found that control over the one central source of drug dispension has reduced the potential for abuse.

The extent to which a pharmacist can use discretion in substituting generic components for brand names cited on prescription forms plays a major role in the use of generic substitutions. State practice acts influence this area of health care delivery. Changes in state laws can contribute significantly to more generic substitutions, and thus lower total outlays for the state and its consumers on prescription drugs.

P. Home Care

An American Hospital Association report estimates that six percent [illegible] hospitalized patients can be treated safely and efficiently at home. Blue Cross of Philadelphia estimates savings of $1.023 per case through its home health program.

Kodak Corporation in Rochester, New York offers employees coverage for home care by visiting nurses. Its coverage, which includes custodial care when needed is not simply limited to follow-up situations after hospitalization. Rather, efforts are made to substitute home care for admissions to hospitals as well. This broad program has resulted in a net savings for Kodak of approximately $160,000/year, and has reduced hospital stays by an average of 21 days/patient as a result of either early release from or nonadmission to a hospital.

This program is also offered community-wide in Rochester to those covered by Blue Cross and Blue Shield of New York. It has done best in areas with low hospital bed ratios, such as Rochester with 3.4 beds/thousand.

Numerous employers have encouraged a timely discharge after the birth of a newborn often providing rebates and a full week of home nursing services for women who leave the hospital the day after delivery. Data reveal a $2.22-$3.19 benefit/cost ratio for early discharge plans that pay mothers $100 bonuses and nursing and homemaker services for a week. A Rochester Blue Cross/Blue Shield plan reduced average length of stay by 2.4 days. North Carolina's state employees receive free post-natal check-ups at two weeks and four weeks if they are discharged within 48 hours of birth.

o Blue Cross of Maryland estimated a $1.4 million savings due to its 1981 home health program that cut 11.4 days per case out of the inpatient setting.

o The Colorado State Employees Plan actively promoted early hospital discharges into a home treatment environment. The savings in 1982 for 51 cases were estimated to be $140 per admission or a net savings of 550 hospital days.

o Penjerdel, a coalition operating in the tri-state region of New Jersey, Pennsylvania, and Delaware estimated savings of $8 per covered employee when a home health benefit was added to insurance packages in the area.

Q. Wellness

Health Promotion and Disease Prevention

Perhaps the greatest savings that can be achieved lie in the area of disease prevention. A mounting body of evidence presages the potential impact that well-designed strategies will have on the overall increase in health care costs. Additionally, the public seems to have come to realize that the nation's acute care hospital systems cannot cure the ills created by health-damaging lifestyle behaviors. Any attempt to promote this fundamental cultural change is bound to result in a healthier population that uses acute health services less.

Fitness

Based on 1982 data, Mesa Petroleum Company of Amarillo, Texas discovered that employees who participate in its fitness program cost the corporation $261 less per person ($434 vs $173) in medical costs and had considerably lower absenteeism rates. The fitness program yielded annual savings on medical expenses of $200,000 in 1982. As a result of these findings, on January 1, 1984 Mesa established a wellness incentive plan (Wellplan), a cash award program for achieving objectives related to good health.

We plan will pay a maximum of $324 in semi-annual payments, to employees who use the fitness center three times a week, do not smoke, have no absenteeism, and no medical claims. Partial payments are made for portions of compliance to any of these four categories. In the first half of 1984, $60,820 was paid out for wellness compliance. Savings are in line with those realized in 1982.

Mesa even goes so far as to buy memberships for its employees working on drilling rigs not within driving distance of company facilities. The plan is still adjusting and under review but employee response has been good.

Risk Screening

At Ford Motor Company, a hypertension prevalence and control program in which the degree of intervention was varied depending on the site, results have been gathered on the value of screening for risks. At the four sites, the most comprehensive treatment and follow-up program yielded the best disease control results.

TABLE 6 **Hypertension prevalence and control rates among Ford employees, University of Michigan project**

	Site 1	*Site 2*	*Site 3*	*Site 4*
Employee population	2,561	4,619	4,316	3,502
Number screened (% work force)	2,121 (83%)	3,453 (75%)	3,314 (77%)	2,308 (66%)
Prevalence of hypertension	16%	19%	17%	13%
Control rates: (blood pressure below 160/95)	(N=211)	(N=555)	(N=493)	(N=88)
Baseline	33%	36%	19%	24%
Final visit	47%	87%	95%	98%

Source: National Heart, Lung, and Blood Institute, *National Heart, Lung, and Blood Institute Demonstration Projects in Workplace High Blood Pressure Control* (draft paper prepared in May 1982).

Based on the findings of its in-house hypertension program, Ford recently designed a software package that incorporates a six-part wellness program, including: smoking cessation, hypertension control, an employee assistance program, nutrition counseling, physical fitness, and stress reduction. The strongest emphasis is on the first three components.

Currently the software is being tested at two Ford sites. Eventually the software program will be phased into all of Ford's divisions to encourage the wellness concept throughout the corporation.

The federal government is considering undertaking a cost-benefit study to determine the financial viability of the use of the wellness software. Uncontrolled high blood pressure victims use from 50-112 percent more health care benefits than employees with normal blood pressure. Added to that is the fact that undetected hypertension is prevalent in 12-20 percent of an average workforce. Consequently, Ford's intervention promises to yield considerable cost savings.

IBM's 16-year old Voluntary Health Screening Program has examined 90,000 plus employees since 1968. The program which is conducted in-house throughout medical departments has detected 41 percent of its employees with previously unknown medical conditions. The program is employed by IBM throughout the country for workers over 35, every 5 years. The early diagnosis and treatment of these previously unidentified abnormalities and diseases has saved IBM significant health dollars, by addressing the medical problems at a point when the treatment costs are minimal as compared to major medical costs that would have eventually been necessitated.

Involuntary Exercise

Revco D.S., Inc., by investing ten minutes a day in exercise for its employees, has cut the number of employee accidents in half at two of its worksites. Twice a day following morning and lunch time breaks, Revco warehouse employees are required to follow a 5-minute stretching routine designed to reduce tension and increase each worker's flexibility.

Unlike other corporations, Revco's program is not structured with any other employee wellness or fitness program. The sole goal of the program is to reduce on-the-job-injuries. The program has worked even better than anticipated; test results have shown that injuries stemming from strains have almost been eliminated. Strains had comprised 46 percent of Revco's warehouse accidents and consumed 55 percent of the company's workman's compensation benefits. The exercise program which has even improved productivity has been made mandatory at Revco warehouses throughout the nation. Employees and union representatives alike have responded enthusiastically.

Smoking and Obesity Reduction

Health Guard at Pioneer Hi-Bred in Iowa in its sixth year of operation has maintained a yearly reduction in the rate of undetected "serious abnormalities" from 6 percent to 1 percent of the workforce. (Approximately one-half of these findings occur with new employees.) The weight reduction program component includes a financial incentive for successful participation. Ninety percent of the participants have achieved some lasting weight loss, while one-third have reached ideal weight. The smoking cessation program also has financial incentives and has reported curtailment for 16 percent of its participants over a two-year period.

The employee response has been enthusiastic. Most feel it is one of the best employee benefits offered. To facilitate compliance, the benefits management is usually combined with health care coordination at the division level, dealing with all program logistics. The success in the implementation of Health Guard has helped spur Pioneer to also expand its EAP to a nationwide status.

- Control Data reported 25 percent greater use of health insurance benefits and a two-fold difference in hospital use between its smoking and non-smoking employees.

IV. CONCLUSION

In examining the collection of examples of successful public and private sector initiatives aimed at slowing the increase in health care cost escalation, it is important to retain several fundamental precepts.

1. Cost management is successfully implemented when all culpable parties in the scenario are included in the solution. The best way to alter the trend lines is to develop a partnership between the payers and the providers. In some communities, physicians have made drastic transformation in their practice styles after being apprised of their abberant behavior. Those changes have enhanced the quality of care and efficiency of those communities' health care systems. The potential exists for every community in this country, should the physician become invested in this kind of fundamental change.

2. Where overall state health care costs have been moderated or successfully managed, a common thread of balanced intervention exists. In states like Iowa and North Carolina, the state has taken a proactive role, but the solution represents a balance between regulation and the free market, a modicum of competition, private sector initiatives, and state mandates.

3. In keeping with the last point, ideologies that embrace competition or regulation will undermine potential for success in managing health care costs. The peculiarity of the patchwork of successful programs and initiatives that has evolved across the country is the contradictory stance between an employer's philosophy about government intervention and an employer's determination to alleviate the financial stress caused by escalating health care costs. It is not uncommon to find an avowed anti-regulatory company pushing for hospital rate setting simply because it represents hope for a solution. In fact, some company's argue for regulation in one state and competition in another. There is no template by which a state or employer can adopt a cost management program that will make an impact. Quite the contrary, each successful program manifests a keen understanding of the specific attributes of the health care system in each community or state. Health care as a product is incredibly different in different states. Seattle is not at all like Miami; Trenton differs greatly from Boise; the HMOs in Massachusetts are not comparable to those in Southern California; etc.

4. At the basis of any effort to arrest the spiraling health care economy should be good baseline data. Regardless of the proposed solution, an accurate understanding of the extent of the problem is imperative. Furthermore, it is apparent that health care as a percent of the GNP will continue to grow due to inexorable phenomena

(e.g., our aging population). That being the case, strategies not even appropriate for this decade – i.e., rationing dialysis – may require justifications based on facts collected in the 1980s. Collecting information on physician practice patterns and charges, though a difficult step to accomplish, would provide the kind of meaningful data required when action is proposed for physicians in the coming years.

5. Though this paper is an amalgam of disparate strategies, employed to nibble away at the margins, eventually bringing down the system's overall increases, by far and away the most important strategy is a comprehensive strategy. Referring back to the introduction, this means focusing on the troika – utilization, reimbursement, and capacity. As a state, New Jersey's rate of increase in admissions and inpatient beds per thousand were fourth and eigth respectively in the nation between 1970 and 1980. Such trend lines do not bode well for the state. In fact, they imply that the capacity issue is not being addressed. The Health Planning Council of Southeastern Michigan calculated savings of $9,000-$27,000 a year for each fully staffed hospital bed that is shutdown due to lack of need. Unconnected programs are not the answer for New Jersey; a comprehensive strategy involving all appropriate parties in the government and private sector is the most meaningful objective for achieving a lasting impact.

6. In light of that point, the most conspicuous ingredient that exists in virtually every example of successful health care cost management is leadership. In fact, the importance of leadership which has long been recognized as a tenet of successful corporate management has only recently gained recognition in this sector of the economy. A more targeted effort to apply well-recognized business practices like good management to the health care system will surely yield palpable benefits.

The 70-80 examples cited in this text have yet to prove themselves over time. They represent exciting developments and appear to promise significant savings. Nevertheless, they are only a first blush in what appears to be a lifetime of action and effort to balance the assets of improving access and treatment breakthroughs while holding down the overall investment in health care.

Washington Business Group on Health

APPENDIX III

HEALTH PROMOTION AT THE WORKSITE

Including:

1) A Focus on Health Promotion in Small Business
2) Small Business Examples of Wellness Programs

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Health Promotion At The Worksite: A Wise Investment

It has been helpful for employers to realize that their prevention efforts are consistent with societal trends. If the 1970's image of health promotion was tainted by tofu, fads, and fitness mania, the image of the 1980's is one of a burgeoning industry with an increasingly strong science base and a value based populace support that transcends any particular programmatic elements. We are in the midst of a shift in lifestyles and priorities, of a movement for self care, independence and new cultural norms that have a major impact upon employer-employee relationships. The leading private-sector firms are responding to this movement. Government, as employer, can feel confident that an investment in health promotion will serve only to keep up with the times, not bring risk of being too far out in uncharted waters.

Evidence of Effectiveness

There will always be controversy over the cost effectiveness of prevention programs. Private-sector employers are used to making decisions on less than perfect evidence and they have moved ahead with investments in prevention programs. Over the past few years there have been numerous studies of prevention programs, many in the workplace. Together, they comprise a very compelling record. More can be found in the media daily:

- THE NEW YORK TIMES and NEW ENGLAND JOURNAL OF MEDICINE reported on a multi-year study of 17,000 Harvard alumni that showed even moderate exercise had a dramatic impact on increasing life expectancy. Death rates for those whose exercise consumed 2000 or more calories per week were one-quarter to one-third lower than those who were less active.

Attached is a compilation of many studies presented for your review, as well as reports on specific health promotion and disease prevention activities such as smoking control, stress management, or the role of small business. Examples of employment based programs are included, as well as data to substantiate the size of the problems being addressed.

Trends

Virtually all major employers today have at least one health promotion/wellness activity, and most have several. Comprehensive programs that include stress management, nutrition, weight control, smoking cessation, physical fitness, alcohol and drug awareness, and seat belt usage, along with such specialized topics as women's health issues, death and dying, medical self care, caring for aging parents are becoming more and more common.

Even small employers are recognizing the contribution wellness programs can make to building morale and generating strong feelings of loyalty among their employees.

Health promotion is no longer the "new" program fighting for its existence in most companies. More and more, it is an accepted and valued part of the corporate structure.

But things are changing--they always do. And Wellness programs will be cutting new inroads as we enter the late 1980s. Here are just a few of the "trends" that appear on the health promotion horizon.

o Health promotion is becoming "institutionalized" as part of major cost management efforts; through a strengthening of the Human Resources Development area, and in corporate medical departments.

- Business is putting more emphasis on improving the "corporate culture," and many of these new forces will relate, at least indirectly, to wellness activities. Business is taking a new look at physical and mental health benefits; personnel policies and practices, especially as they relate to employee stress; environmental policies and practices (adequate lighting, well designed work stations); communications and their impact on employee attitudes and morale; management policies and practices (quality of work life, etc.).

- The changing profile of the worker will demand changes in health promotion programs and in the ways they meet employees' health needs. More women, more minorities, more older workers, greater emphasis on family values, less tolerance for smokers, more concern about mental health.

- Companies will make greater and more effective use of incentives. They cost little or nothing, take little staff time, provide immediate rewards and recognition, and fit with any programs and any sized business.

- Unions' interest in health promotion will grow significantly. In most instances where national unions have undertaken health promotion activities (most often high blood pressure screening and follow-up, stress management, and EAP programs), a significant number of local unions have also picked up the program. Companies also report that local unions appear more and more willing to cooperate in wellness activities.

- Risk assessment and screening are increasingly linked to health promotion programs.

- Employees sharing the cost of programs is increasingly accepted and tends to result in higher participation rates.

- community based programs in hospitals and Y's are increasingly oriented toward the employer market.

- Nationwide networks of health promotion resources are available through such groups as National Health Network (a subsidiary of General Health), U.S. Corporate Health Management, and the Association for Fitness in Business.

Union Concerns

Organized labor has a long and rich history of striving for improved health and safety conditions for workers. The integration of health promotion into the broader safety considerations is well underway in many locals, and at the national level through the Workplace Health Fund. However, many union people remain concerned that support for health promotion with its emphasis on the individual's lifestyle will detract from the still needed emphasis on institutional safety and exposure issues. This is a question of policies and priorities, not a challenge to the value of health promotion. In fact, even workers' exposed to the hazard) of the cope ovens, for example, are much less likely to become ill if they do not smoke. It is our experience that employers should specify that their health promotion programs, as a matter of policy, are designed to advance health, not reduce the employees' safety objectives. Unions, in turn, should welcome health promotion without reducing their own safety efforts.

THE IMPACT OF WORKSITE HEALTH PROMOTION INTERVENTIONS

- SMOKING
- STRESS MANAGEMENT
- NUTRITION
- HIGH BLOOD PRESSURE
- ALCOHOL
- SEAT BELTS
- SMALL BUSINESSES

Smoking

The Office of Technology Assessment of the U. S. Congress (OTA) estimates that smoking-caused illness costs $43 billion in lost productivity annually (or $1.45 for each pack of cigarettes sold), expenses borne largely by employers. Employers also pay a significant portion of another $22 billion in smoking-related health care costs, since nearly two-thirds of the costs are incurred by those under 65. According to OTA, combined lost productivity and health care costs related to smoking equal $2.17 per pack of cigarettes sold (OTA, 1985).

In addition:

- Smoking workers are 50 percent more likely to be hospitalized than nonsmoking workers;
- Absenteeism rates for smokers are approximately 50 percent higher than for nonsmokers;
- Each year more than 80 million workdays are lost due to smoking-related illnesses;
- Smokers' job-related accident rates are twice that of nonsmokers', in part due to loss of attention, hand occupation, eye irritation, and coughing;
- Employers spend an annual average of $300 more in insurance claims for smokers than for nonsmokers;
- When asked whether there should be restrictions on smoking at the workplace, 70 percent of smokers and 87 percent of nonsmokers favored either designated areas or a total ban on smoking.

There also is legal and legislative support for nonsmoking policies. A growing body of court cases and legal opinons indicate that: employees are suing employers for smoke-free work environments; employers must be prepared to bear some responsibility for the discomfort, pain, and iliness caused by smoke in the workplace; and, employers are within their rights in banning smoking at the workplace and in hiring only nonsmokers.

A recent study of the number of sick leave hours per month taken by smoking and nonsmoking employees of Missouri's Department of Health found that during a 20-month period, 97 smokers took 5.3 hours per month sick leave, whereas 309 nonsmokers took 4.3 hours. This represented a 23 percent difference. Excess sick leave was taken by smokers regardless of their sex, marital status, or age group. Average cost for salary and fringe benefits is currently about $20,777 per Department of Health employee, or $82 per work day. An extra 1 1/2 days lost per year for smokers translates to an excess cost of $11,931.

Based on this information and much more, a constantly growing number of employers are reducing or totally banning smoking. Some even are refusing to hire smokers.

One of the nation's largest and best known companies to announce its intentions to work toward a total smoking ban is Boeing of Seattle, WA. In April, 1984, 90,000 employees of the Boeing Company were notifited that the organization had "decided to take additional positive steps toward providing a smoke-free working environment for all employees." While no absolute date was set for the total prohibition, the memo stated "it is the intent of the Company ultimately to do so."

In the meantime, a variety of interim steps were set forth, including prohibiting smoking in numerous areas, offering company-sponsored stop-smoking classes free of charge, and allowing employees to designate the "immediate workplace" as a no smoking area. No less than two-thirds of the cafeterias and lunchrooms also became nonsmoking. Beginning with the April, 1984, announcement, all new hires were informed of the smoking policy. Before instituting the policy, almost a dozen unions were contacted and all supported the move.

Small companies, too, have been aggressive in eliminating smoking from the workplace. For example, Provident Indemnity Life Insurance Company, Norristown, PA, has not only banned smoking, but its smoking employees are warned before being hired that the company pays the full cost of health insurance, but at the nonsmokers' rate. Thus smoking employees must pay the difference between the health coverage rate for smokers and nonsmokers, or about $300 per year.

Stress Management

Chronic stress can have a direct impact on the organization, resulting in absenteeism, poor industrial relations, poor productivity, high accident rates, high turnover, poor organizational climate, low morale, antagonism at work, and job dissatisfaction (Cox, 1980).

Workers, too, perceive stress to be a major problem at work.

- Control Data Corporation (CDC), Minneapolis, MN, reports that in its annual in-house Employee Health Survey, the problem "stress/anxiety/tension" is always at the top of the list, checked by nearly one-third of their employees. CDC has used the same survey at more than 30 other companies with the same result--stress always tops the list of health problems.

- A major insurer, St. Paul Fire and Marine, St. Paul, MN, has found that industrial accidents, productivity problems, health claims, and malpractice claims are clearly related to personal and work stress.

- A study of student nurses found that when several personallly stressful events were experienced, they were apt to be followed by a rash of accidents and job-related errors in the following weeks.

Although formal research into the financial effects of stress management programs on business has just begun, several studies have found that stress management programs can save businesses money.

- One study at the Equitable Life Assurance Society calculated the pre- and post-treatment costs of stress on work, and on relationships with supervisors and coworkers, time away from job due to stress symptoms, clinic visits, and absenteeism. Cumulative cost-benefit ratio demonstrate that for each dollar spent on stress management, the company saved $5.52.

- At New York Telephone, a stress symptoms check list found that 24 percent of participating employees had stress-related symptoms of sufficient severity to warrant intervention, and 10 percent of the group needed psychiatric help. A meditation program (or counseling) was offered to many of these high-risk employees with a high level of success; however, it was impossible to evaluate the effectiveness of the program in terms of dollars and cents. NYT's medical director speculated that if NYT had been able to reach just half of the 24 percent with an intervention program, the company would have reduced the absenteeism by a minimum of 10 percent and saved $2,677 per person just for decreased absence. The cost of the intervention was $300 per person.

Courts recently began awarding workers' compensation benefits to employees who claim their injuries--physical and mental--were caused by stress related to the jobs. Thus, more and more companies are making efforts to reduce stress caused by the job and to help employees manage their own stress. Following are some additional examples of programs that worked.

- A study of 30 insurance company employees with headache and anxiety problems found that physiological, psychological, and work facxtors (absenteeism, productivity) were improved with individual biofeedback training.

- Control Data Corporation (CDC) surveyed 78 employees who elected to take a self-study course in "How to Relax." Using self-report data, 78 percent reported that they were using at least one stress management technique regularly, and 77 percent reported that they payed more attention to the effects of stress.

- In a National Institute of Mental Health-funded effort to explore occupational stress support groups as an intervention to help blue collar and union workers respond to stress, it was found that such a program had a significantly positive effect on physiological, psychological, and work productivity variables.

Nutrition

The relationship between certain dietary habits and six of the 10 leading causes of death has been clearly established. Nutrition plays a role in heart disease, some cancers, stroke, arteriosclerosis, diabetes, and cirrhosis of the liver. In addition:

- As much as 35 percent of all cancers are linked to nutrition according to the National Cancer Institute;
- Poor nutrition in pregnant women is a contributing factor in low birthweight babies, a leading cause of death among infants;
- An estimated one-third of the American population today is obese to the extent of decreasing their life expectancy (U.S. Senate Select Committe on Nutrition and Human Needs, 1977). An estimated 16.7 million workers are more than 20 percent above their desired weight, or obese (NHLBI, 1983).

Improvement in eating habits have been shown to reduce the risk of serious health problems.

- In at-risk individuals, weight loss has been found effective in reducing both blood pressure and cholesterol levels.
- Weight control and diet regulation are central to the control of non-insulin-dependent diabetes and can prevent secondary symptoms and complications.
- Low-fat eating patterns can reduce high blood cholesterol levels and decrease the chances of a heart attack.

- Dietary management can reduce the need for long-term medication use for treatment of hypertension in some patients.

Because of their beliefs that nutrition education will help improve the health and productivity of their employees, many large companies have multi-component nutrition programs as part of their overall wellness efforts.

- Campbell Soup Company began its atherosclerosis Prevention Program in 1968. About 35 percent of the employees who completed a medical screening at that time were found to have elevated cholesterol levels. They were advised to follow a prudent diet, and about 50 percent were still following the diet one year later. Campbell's program now includes dietary counseling for reduction of weight, cholesterol and hypertension. Weight-loss contests have been conducted to help employees lose weight.

- At Kimberly-Clark, Neenah, WI, employee health promotion has been a tool for improving health, recruiting employees, and enhancing the company image. Occupational nurses refer employees to the program, which also is available to spouses and retirees. Kimberly-Clark offers several nutrition courses, with both information and behavior modification emphasis. Individual and group nutrition counseling are available, and changes have been made in cafeteria offerings, such as providing low salt, low fat foods.

- Among the core "action programs" offered in Johnson & Johnson's "Live for Life" program are a 10-session weight control program and an eight-session nutrition program emphasizing prudent eating patterns. As part of the emphasis on creating a healthful environment, there are scales in the restrooms, nutritious foods available in cafeterias and vending machines, and nutrition informainformation available where food is sold.

- Southern New England Telephone offers a varied program entitled "Reach Out for Health." After screening and individual health counseling, employees may enroll in several nutrition courses: an eight-week behavior modification weight control program, a six-week Nutrition Awareness course, and short courses such as Nutrition Potpourri, Pressure Cooker, and Nutrition Nonsense. The cafeteria program includes point of purchase nutrition information and informational flyers. Preliminary evaluation data show reductions in weight, cholesterol, triglycerides, and blood pressure.

High Blood Pressure

A growing number of employers are establishing worksite hypertension programs for their employees; indeed, according to several surveys, high blood pressure detection and control programs are among the most popular health promotion offerings. Despite the high prevalance of this silent killer, which is a major risk factor in stroke and coronary heart disease, a number of relatively inexpensive treatments and easy-to-administer screening techniques are available.

High blood pressure can be expensive if it remains uncontrolled.

- The average employee with high blood pressure costs a company between about $270 and $460 a year in lost output.

- Approximately 29 million work days, representing more than $2 billion in earnings, are lost each year because of hypertension, heart disease and stroke.

- These illnesses are the primary cause of hospitalization, accounting for 7.5 percent of all physician office visits and six percent of all lost work days.

- As a group, white men between the ages of 45 and 54 lose annual earnings of $455 million from hypertension alone; black men in the same age group lose $32 million.

Following is a small sampling of successful company-sponsored high blood pressure programs.

- Each year since 1980, 60 percent of General Motors employees have been screened by specifically trained company health professionals, with the assistance of the American Heart Association. Program convenience is particularly attractive to GM employees.

- At Campbell Soup Company, nurse practitioners screen, educate, and treat hypertensive employees. An onsite program is available for those without a private physician. Costs per patient of onsite treatment is $96 per year, compared with about $300 per year for care by a private physician. About 60 percent of the company's hypertensive employees are currently receiving treatment; at some plants the figure is as high as 80 percent.

- A high blood pressure program has been offered to 1,344 millworkers in five plants of Burlington Industries. Specifically trained company nurses screened, referred, monitored, and counseled participants after an initial education campaign. About 80 percent of enrolled hypertensive employees now have their blood pressure under control.

- About 25 percent of the 275 employees at Macalloy Corporation, a steel mill in South Carolina, have high blood pressure. Most of the union members are high risk, black, blue-collar workers in their mid 40's. Through frequent contact with the company nurse, 100 percent of the hypertensive employees have adhered to treatment. The nurse involves family members in the treatgment program, which includes aggressive follow-up. Union support is strong.

Alcohol

Alcohol resulted in a $65.6 billion productivity loss in 1983 (NIAAA). The Office of Technology Assessment sets the figure as high as $120 billion annually. Another $12.7 billion is spent on medical care costs related to alcohol abuse (NIAAA). OTA estimates that alcohol abuse may account for up to 15 percent of the nation's health care costs because alcoholics use significantly greater amounts of medical services than nonalcoholics. Alcohol and other drug abuse problems affect about eight percent of the workforce, and seven million workers are alcoholics (NIAAA). Roughly half of the alcoholic workers are in supervisory positions.

Employees with alcohol and drug problems have:

- absenteeism rates two to three times the norm;
- health care claims three to four times the norm;
- accident rates three to four times higher than normal;
- increased incidence of workplace violence;

- high turnover;
- low productivity;
- more grievances;
- greater tardiness.

It is estimated that troubled employees cost companies 25 percent of their actual payroll dollars because of these factors.

Seat Belts

Traffic crashes are America's leading cause of work-related injury deaths. More than 36 percent of the 11,300 accidental work deaths in 1983--about 4,100--involved motor vehicles. In addition, about 60 percent of the 32,900 workers killed in off-the-job accidents in 1983 (about 20,700) died in motor vehicle crashes. It is estimated that each motor vehicle death costs society over $330,000 in lost wages, medical costs, insurance expenses and other related costs. In addition,

- The cost of all crashes average $308 per year for every man, woman and child in the U.S.

- Total medical costs per critical injury average $138,000.

- American employers pay for 45 million days work lost annually for motor vehicle crashes.

- Motor vehicle crashes cost society about $69.5 billion annually, of which $19 is due to lost productivity and medical costs (NHTSA, 1985).

In an analysis of the economic costs to the Commonwealth of Pennsylvania emphasizing the importance of safety belt use between 1979 and 1982, it was estimated that the Commonwealth could have saved $11,968,312 if the moderately injured or fatally injured state employees had been wearing safety belts.

Between 1977 and 1983, Fort Motor Company analyzed their losses resulting from traffic crashes among employees and retirees. Their calculations revealed that for every one employee who died in the plant, 13 others were killed on the highway. An additional 13,700 incurred disabling injuries. These figures do not include dependents killed in motor vehicle crashes. At the same time, surveys revealed that only 3.6 percent of employees used safety belts. Based on these statistics, Ford estimated that for every 10 percent increase in safety belt use among employees each year, they could expect to save the lives of three employees and prevent injuries to 121 others. This would save the company three and three-quarters million dollars annually in medical, insurance, disability and replacement costs (Gray, 1985).

Following are examples of just a few companies that have instituted seat belt education programs.

- o The Alcoa Technical Center, Pittsburgh, PA, increased safety belt usage from 43 percent to 92 percent through a program involving education and incentives.
- o Johnson & Johnson, New Brunswsick, NY, through a "Saved by the Belt" club promotion, increased their employees' use of belts from 20 percent to 50 percent during an 18-month period.

- DuPont in Florence, SC, established a comprehensive program for employees, families, and the community. At the end of the first month, the employee usage rate was 84 percent, up from 31 percent before the program started.

- PPG Industries, Pittsburgh, included the families of employees in all efforts to educate them about safety belts and child auto restraints. The program included articles in company newspapers, video presentations, promotional material received at home, and incentives of a free child safety seat to PPG employees or dependents who give birth.

- Before implementing a seat belt education program, DuPont's Waynesboro, VA, plant had experienced 394 lost work days due to motor vehicle accidents, 14 non-work injuries due to accidents, and only 25 percent of the employees used seat belts regularly. Following an extensive, but inexpensive campaign with incentives, three years later the figures were just 51 lost work days, 7 non-work injuries and 88 percent of employees wore seat belts, even after the incentives were withdrawn. In 1984, the plant had just one accident and one lost work day due to motor vehicle crashes.

Small Businesses

When Americans think of a "business," they usually think first of a big business--IBM or Chrysler or AT&T. But the vast majority of all US companies--more than 99 percent--are small, according to the latest statistics from the Small Business Administration. Even a big company like IBM is made up of several hundred small, medium, and large units scattered all over the country, with most classifed as "small" (that is under 500 employees). According to the SBA, there are 4.7 million small business establishments in our country today.

In terms of jobs, more than half of all employed people in the US (57.9 percent) work in businesses with betweeen two and 500 employees. Almost 45 percent of all wage and salary employees work in companies with fewer than 100 employees.

But the fact that a business--or a worksite of a larger organization--is small is no reason why it cannot have a viable and effective health promotion program.

Look at these examples.

o Many of the 120 employees of Safeway Bakery Division, Clackamas, OR, start work at a different time each day, but they see their health promotion program as an excellent way to help manage their stress and keep morale high.

  - Following a vigorous promotional/information campaign, 117 of 120 employees signed up for the program's initial fitness assessment.
  - Employees built a fitness facility and all the equipment on their own time.
  - Employees manage the facility and pay dues to cover all expenses. They also select programs to be implemented by the employees themselves or by a consultant who works for the employee group.
  - The fitness facility is open to employees, families, and friends 24 hours per day.

- A part-time fitness expert conducts exercise classes plus nutrition, sports injuries for children, weight training, hair styling, and much more.

- Smokers and nonsmokers use separate lunch areas; profit from cigarette machines in the smokers' lunch room paid for a color TV for the smoke-free area.

- A "Health in Humor" clinic teaches employees to laugh at themselves and to manage stressful situations.

o Plaskolite, Inc., a 300-employee light manufacturing company in Columbus, OH, undertook a health promotion program in 1981 because of an increase in health care costs coupled with a commitment to high quality employee health by the company president.

- An exercise facility on-site is open to all employees and dependents at no chargae.

- Six-week smoking cessation classes are presented twice a year for employees and dependents.

- Smokers who quit or employees who have never smoked are given a $200 yearly bonus.

- Stress Management classes are open to employees and dependents without charge.

- Weight reduction classes are offered.

- The company nurse conducts a variety of annual and periodic screenings, including blood pressure, glaucoma, diabetes, hearing, and health risk appraisals.

- Each month a different employee group meets with the administrataor to discuss safety hazards. The group is responsible for photographing hazards; once maintenance is notified, it has two weeks to correct the situation.

- A toll-free number is available for referrals to an employee assistance program run by a community agency. Each employee has available up to six free sessions per referral problem.

- The administration believes the program has had a positive impact on both employee health and overall health care costs. Although no direct correlations can be drawn with the wellness program, health care costs have gone down in each of the last three years.

COMPANY EXAMPLES — SMALL BUSINESSES

Following are examples of wellness programs in small businesses illustrating just some of the kinds of activities being undertaken to help their employees stay healthy. Many of these summaries highlight selected parts of the companies' effort and do not necessarily reflect the full scope of their health promotion programming.

Maupintour, Lawrence, KA
Pete Anderson, Director of Trade Relations, (913)843-1121.
Thirty employees work at the headquarters office in Lawrence (program described below) and 100 are tour managers around the world.

- No smoking is permitted in the facility or on grounds.
- A new building (three years old) includes a health facility with gym, treadmill for running, weights, lockers, sauna, etc., which is open to spouses and guests of employees.
- Complete physical fitness profile and exercise goal setting is required before using facility.
- Employees who meet monthly fitness goals, set by themselves and a fitness expert, win Maupintour t-shirts, shorts, warm up jackets, etc.
- Although initial investment in the facility was high, maintaining the program is a low cost, high payoff item.

Stevens Real Estate, Lawrence, KA
Bob Stevens, President, (913)841-4500.
Of 50 employees, 41 are salespersons and nine work in the office.

- Forty percent of the employees are certified in CPR; classes have been offered at the worksite three times and are open to spouses and children of employees, as well.
- Mini-trampolines are used by emloyees, including by sales people, while listening to sales training tapes.

Bodolay-Pratt, Lakeland, FL
Richard W. Smith, Divisional President, (813)686-5151
This 75 employee firm builds packaging machinery.

- Company is on a tight budget, so it looks for free or low cost programs.
- High blood pressure and glaucoma screening is provided through a local hospital.
- Cigarette machines were removed to help employees who wanted to quit.
- Because of a "family" orientation of management, company seeks activities that can be done as a group.

Provident Indemnity Life Insurance Company, Norristown, PA

Maryann Fichter, Director of Personnel (217)279-2500

Strong support from the company president gave impetus to wellness programming for the 90 headquarters employees.

- An employee committee manages the program.
- All employees receive a health risk appraisal and personalized feedback.

- No smoking is allowed in the company; in addition, smokers pay a higher life insurance premium than nonsmokers.
- Monthly educational programs cover stress, nutrition, hearing testing, high blood pressure screening, etc.
- An exercise class designed to trim inches attracted 50 percent of all employees to the first session.
- A walking club meets at lunch time.
- Ninety-one percent of all employees participated to win points (for such healthy activities as wearing seat belts, learning CPR or first aid, attending monthly educational programs) toward prizes such as a sweat suit and gym bag.
- A weight loss program is conducted by the local Dairy Council.
- Employees receive bonus pay for not using their sick leave.

Safeway Bakery Division, Clackamas, OR
Bob Jacobson, President, (503)657-6441
Many of the 120 employees of this bakery may start work at a different time every day, but they see their health promotion program as an excellent way to help manage their stress and keep morale high.

- Following a vigorous promotional/information campaign, 117 of 120 employees signed up for the program's initial fitness assessment. Management attributes this strong response to the fact that the employees were responsible for setting the program up.
- Employees built a fitness facility and all the equipment of their own time.
- Employees manage the facility and pay dues to cover all expenses; they also select programs, to be implemented by employees, themselves, or by a consultant/director, ranging from makeup consultation to a Halloween aerobics class.
- The fitness facility is open to employees, families, and friends 24 hours per day.
- A part-time fitness expert conducts exercise classes plus nutrition, sports injuries for children, weight training, hair styles, etc.
- A fitness assessment and prescription are required before joining the fitness facility.
- Smokers and nonsmokers use separate lunch areas; profit from cigarette machines in smokers' lunch area paid for a color TV for the smoke free area.
- A "Health in Humor" clinic teaches employees to laugh at themselves and to manage stressful situations.
- Points gained through regular fitness evaluations earn t-shirts containing the company's wellness theme, "Buns on the Run."
- Management credits the wellness program, at least in part, for dramatic reductions in industrial accidents, absenteeism, and employee turnover, as well as improved employee recruitment.

Sherer Brothers Lumber Company, Minneapolis, MN
Robert Peters, Director of Health Promotion, (612)379-9633
One hundred employees perform physical labor and the remaining 50 are salespeople.

- Management's stated philosophy for the health promotion program is "to create and support a healthy lifestyle and attitude, both in the workplace and at home."
- A variety of programs have been presented including the American Cancer Society's quit smoking program, back injury prevention, blood pressure monitoring and a weight loss contest.

- The "company culture" has been made healthier by removing cigarette and candy machines, adding fruit dispensers, replacing caffeinated coffee with decaffeinated, providing free healthful lunches and snacks, installing dust collection equipment, refixturing all lighting and providing safety equipment for all yard workers.
- A "well-pay" article in the union contract rewards employees who are not absent or late, and who have no lost time due to injuries.

First Interstate Bank, Santa Fe, NM
Sharon Lieber, Director Human Relations, (602)271-6418.
One hundred and fifty employees work at the main office and four branches.

- Brown bag luncheon speakers are scheduled periodically.
- The company arranges discounts for health club memberships.
- Every Wednesday morning fruit is available free to employees at all branches. (Donut consumption has been cut by 75 percent with the introduction of the fruit.)
- Employees and their family members may take advantage of six visits to a counseling service for personal problems such as marital difficulties, emotional problems or drug/alcohol conditions.

Simpson Timber Company, Seattle, WA
Mary Biller, Secretary, (206)292-5218
One hundred employees work at the headquarters office. Other locations have their own programs, some more extensive than the corporate office program.

- In response to concerns of rising health care costs, programs were developed to help employees stay well and learn to use the health care system wisely.
- Employees are allowed to run the program and choose the classes to be offered.
- High blood pressure testing and monitoring has been offered four times per year at the worksite by the Red Cross.
- Lunchtime speakers have discussed nutrition, safe driving, smoking, self-defense, cancer, CPR and other topics.
- Exercise has been encouraged through a walk-a-thon treasure hunt with drawings for gift certificates.

Green Giant-Pillsbury, Glencoe, MN

Connie Berry, Occupational Health and Safety Administrator, (612)864-3151

This food packing plant has 160 year-round employees. Limited programs are available for the seasonal employees.

- An annual screening includes height, weight, blood pressure, blood analysis, grip strength, vital capacity, flexibility and a three-day nutritional analysis.
- A series of evening educational programs discuss the blood analysis results, exercise, maintaining appropriate blood pressure, nutrition, motivation, stress, etc.
- Each fall a smoking cessation program is presented by the American Lung Association. "Sponsors" assist and encourage the would-be quitters. Those who quit for 60 days get their fee returned plus a bonus.
- A high school swimming pool is reserved for Green Giant employees one hour each night after work, October through May.
- Spouses are invited to all events and programs.

Plaskolite Inc., Columbus, OH
Jim Weidaw, Employee Relations Director, (614)294-3281
This 300-employee light manufacturing company undertook a health promotion program in 1981 because of an increase in health care costs coupled with a commitment to high quality employee health by the company president.

- An exercise facility on-site is open to all employees and dependents at no charge. A full-time staff person helps employees set individual fitness goals.
- Six-week smoking cessation classes are presented twice a year for employees and dependents.
- Smokers who quit or employees who have never smoked are given a $200 yearly bonus.
- Stress management classes, conducted by the company nurse, are open to employees and dependents without charge.
- Weight reduction classes are conducted by the company nurse and a fitness consultant.
- The company nurse conducts a variety of annual and periodic screenings, including blood pressure, glaucoma, diabetes, hearing, and health risk appraisals.
- Each month, a different employee group meets with the administrator to discuss safety hazards. The group is responsible for photographing hazards; once maintenance is notified, it has two weeks to correct the situation.
- A toll free number is available for referrals to an employee assistance program run by a community agency. Each employee has available up to six free sessions per referral problem.
- The administration believes the program has had a positive impact on both employee health and overall health care costs. Although no direct correlations can be drawn with the wellness program, health care costs have gone down in each of the last three years.

Sky Brothers Inc., Altoona, PA
Kathy Knisely, Corporate Risk Manager, (814)946-1201
Three hundred and fifty Altoona area employees work in various areas of this wholesale food company including trucking, computer center, sales, and warehouse.

- The company pays one-third (up to $50) of the membership in selected health clubs, Ys, etc; if the employee meets fitness goals, reimbursement of an additional one-third of the fee (up to $50) will be made.
- A fitness expert conducts quarterly fitness assessments for employees and spouses, and sets fitness goals.
- Assessments are conducted on-site and on company time because management has seen payback through reduced sick days and reduced back injuries.
- Smokebusters class is presented by the local Tuberculosis Society.
- An employee assistance program is offered, on a confidential basis, through a community counseling group.

APPENDIX A

Washington Business Group on Health

WORKSITE HEALTH PROMOTION PROGRAM RESULTS

INTRODUCTION

Employers and health care providers in many communities across the country are increasing their investment in health promotion and disease prevention. As they face an increasingly diverse selection of program options, many want evidence that savings -- in health, productivity, and dollars -- can actually be achieved.

This paper is provided in response to this need for effectiveness information.

A substantial body of data has accumulated which demonstrates the need for health promotion programs and the variety of benefits employers and employees can receive from them. These benefits include reduction in benefit costs, such as health, life, and workers compensation insurance; improvements in productivity, such as increased employee morale, decreased absenteeism, improved ability to perform and the development of high quality staff, reduction in human resource development costs, such as decreased turnover and greater employee satisfaction; and improved image for the corporation.

This paper will address: 1) the scientific evidence substantiating the need for health promotion; 2) the statistics demonstrating the cost of illness to business; 3) the results of comprehensive programs established by various corporations; and 4) various components of health promotion programs (such as smoking, fitness, hypertension, weight loss/nutrition, alcohol/drug abuse, stress and back injury programs).

This is by no means all of the issues dealt with in health promotion programs but only a brief overview.

SCIENTIFIC EVIDENCE FOR THE NEED OF HEALTH PROMOTION

- The ten leading causes of death (heart disease, malignant neoplasms, stroke, accidents other than motor vehicle, influenza and pneumonia, motor vehicle accidents, diabetes, cirrhosis of the liver, arteriosclerosis, and suicide) account for approximately 80 percent of all deaths and have been linked with risk factors which can be affected by changes in personal behavior.

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The Alameda County Study followed 6,928 persons for a period of nine years. Some of the more significant findings are:

- . Seven health practices were found to be related to physical health status and mortality -- never smoking cigarettes, regular physical activity, moderate or no use of alcohol, 7-8 hours of sleep regularly, maintaining proper weight, eating breakfast, and not eating between meals. Further statistical analyses revealed that two of these practices did not independently contribute to health status and mortality (eating breakfast and eating between meals).
- . Men who followed six or seven of these practices were as healthy as men who were 30 years younger but followed only one or two of the practices.
- . A 45-year old man who followed six or seven of the practices could expect to live 11 years longer than the 45-year old man who followed only one or two of the practices. For women the difference in longevity was seven years.
- . Men with three or fewer of the health practices had a standard mortality ratio of 1.73 compared to a ratio of .71 for men with six or seven practices. Women with three or fewer of the practices had a standard mortality ratio of 1.60 compared to a ratio of .80 for women with six or seven of the practices.

The Framingham Study was the first to demonstrate correlations between cardio- vascular disease and behavior related factors such as obesity, cigarette smoking, and hypertension. Among the more significant findings of the study are:

- . Cigarette smoking is the strongest observed risk factor for sudden caridac death.
- . Hypertensives have twice the risk of developing coronary heart disease as do normotensive persons.
- . Weight gain is associated with an elevation in blood pressure.
- . The rate of coronary heart disease for men with sedentary lifestyles is about three times higher than that for active men.
- . Obesity is a significant independent predictor of coronary heart disease.

- The Framingham Heart Study concludes that at least 10 percent of the work force has a minimum of at least 2 coronary risk factors and this group accounts for a disproportionate, 40 to 60 percent of a company's health care costs. If only one-quarter of these high-risk individuals reduced their risk factors, company health expenditures could be reduced by 10 to 15 percent annually.

The Hypertension Detection and Follow-up Program (HDFP) determined the effect of a systematic approach (i.e., stepped-care) to the treatment of hypertension. The results demonstrated the importance of designing health promotion programs which are specific interventions directed at risk factors or disease. Among the most important findings of the study are:

- The five-year mortality from all causes was 17% lower for the stepped-care approach; there was a 45% difference in the number of deaths from cerebrovascular disease in favor of the stepped-care approach, and there were 26% fewer deaths from myocardial infarction in the stepped-care group. Also, five-year mortality from all causes was 20% lower for participants receiving stepped-care who were classified as having "mild" hypertension (90-104 mmHg).

- The stepped-care approach resulted in a large reduction in diastolic pressures for all age groups, both sexes, and for black and white participants than did the referred care group (referred to physicians for "usual" care).

- After five years 64.9% of the stepped-care group had reached the diastolic goal of 90 mmHg versus 43.6% of those in the referred-care group.

The Stanford Three Community Study determined if risk factors could be changed using a variety of mass media techniques and in one community supplemented by face to face communications. The three communities studied were Tracy, Gilroy, and Watsonville and the major findings are:

- Men in Watsonville receiving the intensive intervention (mass media and personal communications) had significantly greater decreases in total plasma cholesterol levels than men in Watsonville who were exposed only to the mass media messages.

- Gilroy and Watsonville participants had significantly greater reductions in consumption of foods high in saturated fats or cholesterol than did participants in Tracy.

- At the end of the third year the cardiovascular risk score of Tracy participants increased by 3.3%. The three experimental communities all recorded decreases -- 8.8% for Gilroy, 12.8% for Watsonville (media only), and 15.2% for Watsonville residents who received mass media and personal communications.

- High risk participants in all three communities had reductions in their cardiovascular risk scores after three years: Tracy (-8.0%), Gilroy (-16.1%), Watsonville media only (-23.1%), and Watsonville media and personal communications (-29.0%).

The Multiple Risk Factor Intervention Trial (MRFIT) tried to determine if a special intervention (SI) program designed to simultaneously lower blood pressure, reduce serum cholestoral, and eliminate cigarette smoking would result in a significant reduction in mortality from coronary artery disease. Some of the more important findings are:

- There was 10.5 mmHG decrease in diastolic pressure for the SI group 72 months following collection of baseline data compared to a 7.3 mmHg decrease for the UC group (P<.01).

- Participants in the SI group reduced their total plasma cholesterol after six years by 12.1 mg/dl compared to a reduction of 7.5 mg/dl for the UC group. (P<.01).

- For men smoking at the start of the study 50% in the SI group and 29% in the UC group reported having stopped smoking (P<.01) after six years. The thiocynate-adjusted quit rates were 46% for the SI group and 29% for the UC group (P<.01).

- Mortality from coronary heart disease was 17.9 deaths per 1000 in the SI group and 19.3 per 1000 in the UC group — a statistically nonsignificant difference.

Lipid Research Clinic's Coronary Primary Prevention Trial was the first study to demonstrate that the risk of coronary heart disease can be reduced by lowering blood cholesterol levels. The greater the reduction in total and LDL cholesterol levels the greater the reduction in coronary incidence. It can therefore, be reasonable to expect from the results of this study that a one percent reduction in total cholesterol will result in a two percent reduction in risk for a heart attack.

The above noted evidence directly relates some risk factors to the development of disease. The evidence also indicates that it is possible to reduce the number or magnitude of an individual's risk factors through designing and implementing interventions that motivate behavior changes. The following sections examine specific behaviors/symptoms/programs in regards to their effectiveness and reduction of costs.

COST OF ILLNESS TO BUSINESS

. Americans spent $300 billion on health care in 1982 and will spend $1 trillion by the year 2000. Of the $300 billion, approximately 97 percent went toward curing disease while only 3 percent was spent on prevention.

. American business paid $77 billion in total health care related expenditures in 1982.

. Premature death costs industry 132 million lost days of output each year at a cost of $25 billion. Heart attack alone accounts for 52 million days of lost output each year at a cost to employers of $50 billion.

. Almost 60 percent of the losses to the American economy due to chronic ill health can be prevented by fitness programs and healthful lifestyles.

. Since 1968, IBM has had a multiphasic screening program that provides all 35-year old employees with a battery of physical tests as well as a questionnaire which focuses on medical history and identifiable risk factors. The overall findings of this program are striking. Forty-one percent of those screened had a "unknown medical condition" (i.e., of which they were not previously aware).

. Health care costs at Chrysler added more than $500 to the price of each vehicle they manufactured in 1982.

. Low back injury alone costs industry $1 billion a year in lost output in addition to $250 million in workers' compensation claims. It is estimated that low back injury is present in 30 percent of this country's work force, even excluding chronic, pathological injuries.

COMPREHENSIVE PROGRAMS

A few corporations have established very comprehensive health promotion programs and have conducted extensive evaluations to determine the savings and benefits reaped by the corporation.

. Control Data Corporation. An examination of six years of data produced the following findings: In every case except for one (smoking males under 40), the claims dollar are higher for the high-risk individuals (heavy smokers, those overweight, etc.) than for the low-risk individuals. On the average, an unhealthy employee cost Control Data $509 dollars more annually than a healthy one. In addition, high-risk employees had a 5 percent higher absenteeism rate than low-risk employees.

. Two years of data from Johnson and Johnson's Live for Life program demonstrated dramatic results in two areas: 1) a positive progression towards making an employee's lifestyle more healthy (i.e., by helping that person stop smoking or lose weight), and b) improving the employee's physical health (i.e., by lowering blood pressure).

. Blue Cross & Blue Shield of Indiana offered its employees a comprehensive health promotion program which was evaluated after it had been in place for 5 years. It demonstrated that the average savings per employee was $143.60 and the average program cost per person was $98.86. Thus, there was a savings to cost ratio of $1.45 or, in other words, one dollar invested in health returned a dollar and a half in saved insurance benefits utilization.

. New York Telephone, which has 80,000 employees, estimates an annual savings of of $663,000 from its alcohol control program, $267,000 from its breast cancer screening program, $302,000 from its back treatment program, and $268,000 from its stress management program.

. Canada Life Assurance found that program participants had a 1.15 percent turnover rate compared to a 15 percent rate for employees who did not participate. Forty-seven percent of fitness program participants reported that they were more alert, enjoyed their work more, and had better rapport with co-workers and supervisors since the program began.

- AT&T has estimated that its Total Life Concept health promotion program may reduce medical costs incurred from potential heart attacks over a 10-year period by $22.4 million. They also estimate that the reduction in incidence of cancer could create projected savings of $17.5 million over a ten-year period.

- The Lockheed Missles and Space Company estimates that since 1978, it has saved $1 million in life insurance costs as a result of its employee wellness programs.

- A five-year experimental fitness and heart disease intervention, program involving 847 New York State employees found that, in addition to reducing coronary risk factors in participants, one year after implementation of the program, sick leave among fitness program participants was reduced 43 percent, or an average of 3.3 days per employee.

- ARCO has estimated that its ARCO Health Enhancement Program (AHEP) has the

  > "potential of saving the company over $55 million a year if only its hypertension screening, smoking cessation, breast self-examination, and colorectal cancer educational programs were offered; and if all at-risk employees were active participants and scrupulously followed prescribed health practices"

  It must be kept in mind that this figure has been arrived by using

  > "statistics based on a population size of 37,000 employees, with a four-to-one ratio of men to women and an average annual salary of $40,000 or $154 a day. The onset of most illnesses discussed occurs after age 40, at which point the average employee will have been with ARCO for 15 years. Short-term disability benefits after 15 years of employment are 15 weeks at full pay and 37 weeks at half pay, with benefits averaging $26,000. Long-term disability averages about 40 percent of salary or about $16,000 a year. Employees with terminal illnesses were assumed to die after collecting an average of three years long-term disability, totaling $48,000. Permanent replacement cost for an employee averaged $20,000 where it is applicable. This is based on the expense of advertising, use of an employment agency, interviewing, time off for internal employees, relocation, processing, use of an experienced employee to provide training and the supposition that a new employee is not up to full efficiency for six months".

SMOKING

Some of the direct costs to industry from smoking include increased illness, accidents, absenteeism, disability, and mortality rates; decreased productivity, and increased medical costs.

. Estimates of the total costs to the employer for each smoker range from $624 to $4,611 annually.

. Smokers are ill 50 percent more often than nonsmokers.

. Early disability and mortality rates for smokers are almost 300 percent higher.

. Each year more than 80 million workdays are lost due to smoke-related illnesses.

. Smokers' accident rates are twice that of nonsmokers due in part to loss of attention, hand occupation, eye irritation and coughing.

. The cost of down time spent on smoking-related activity was estimated at $500 per year per smoker based on 30 minutes a day at $4 per hour; $900 for a pipe-smoker.

. The American Lung Association approximates that smoking adds $13 billion every year to direct health care costs in the United States. Employers pay nearly half this cost.

. Costs for fire insurance, workers' compensation, life insurance, and disability insurance are higher for those industries which permit smoking in the work place. Smokers are responsible for a disproportionate share of health, automobile and disability insurance claims.

. Smokers cause damage to furniture and carpeting in the form of maintenance costs at an average annual cost of $120 per smoker.

. Physical plant costs also are higher when there are large numbers of smoking employees. For areas of a building where smoking is permitted, the recommended rate of indoor/outdoor air exchange is five times that for areas where there is no smoking. The expense of heating and cooling such a large amount of outside air is already staggering and is increasing as energy costs rise.

- Over one-third of the employed population currently smokes cigarettes; those who smoke have ten times the risk of developing lung cancer and two times the death rates due to coronary heart disease.

- Provident Indemnity Life Insurance Company eliminated smoking on its premises in September 1983 and found that, after one year, absenteeism was down, the air was cleaner, approximately $15,000 to $20,000 was saved in smoking-related damages and cleaning, there were virtually no complaints from employees, and job applications increased.

- The Control Data evaluation confirmed the relation between health habits and health care benefits payments. For example, current smokers and those who quit less than five years earlier generated 25 percent more benefits payments and twice the number of hospital days as those who either never smoked or quit within the previous five years.

- Jonathan Fielding also reports that smoking cessation programs at the worksite have achieved a 40-60 percent abstinence rate over a 6-12 month period, compared to 15-30 percent abstinence rate achieved through community programs.

- An Owen Corning Fiberglass Technical Center has shown a drop from 70% to 12% smoking rate, and Upjohn Company has achieved a 40% quit rate. Metropolitan Life Insurance Company has sustained a success rate of 35% for the participants in their smoking cessation classes, and the company estimates a savings of $345 for each ex-smoker.

FITNESS PROGRAMS

- Physiological changes reported from some but not all programs include reduced blood pressure, improved ability to manage weight and reduced feeling of stress. A few clinical studies suggest that aerobic exercise can reduce feelings of sadness and help combat depression. The degree to which regular exercise can help to reduce other deleterious health habits, such as smoking or drug addiction, is not known. In postmenopausal women, exercise can decrease bone loss (osteoporosis).

- Many studies suggest that vigorous fitness and lifestyle programs reduce the incidence of fatal heart attack by as much as 50 percent, resulting in a substantial reduction in related costs due to premature death, medical and disability insurance.

- The Canadian Fitness and Lifestyle Project found that employees designated as "high adherents" to regular exercise reduced absenteeism by 42 percent, or 2.5 fewer days absent per active participant, following the initiation of an employee fitness program. Extrapolated to the company's 1,400 employees, this improvement would achieve a direct savings to the employer of $175,000 a year. Further, the turnover rate demonstrated by the "fit" group was 13.5 percent less than for the company as a whole. Economically, this represented an annual savings of $510,000 in hiring and training costs.

- A Canadian study relating physical fitness to the frequency of doctor and hospital visits found, after one year, employees from a company with a fitness and lifestyle program decreased hospital utilization and medical claims relative to employees from a control company without a program. The total health care savings amounted to $233 (U.S.) per employee per year for the company with a fitness program.

- In the Canada Life Assurance Study, a 4 percent increase in productivity was shown by the experimental group, in comparison to the control group, following the initiation of an employee fitness program. this improvement represents an average increase in productivity of approximately $116 per worker per year.

- Swedish investigators found that mental performance following exercise was significantly better in the physically fit than in the non-fit person. Results suggested that fit workers committed 60 percent fewer errors on tasks involving concentration and short-term memory as compared to the "unfit" worker.

- Studies by the National aeronautics and Space administration and the Heart Disease and Stroke Control Program concluded that a program of regular exercise reduced absences, improved stamina and work performance, and enhanced concentration and power of decision-making. In contrast to the average office worker whose efficiency decreases 50 percent for the final 2 hours of the working day, the exercise program participants worked at full efficiency all day.

- Tenneco found that employers who participate in a regular exercise program are more productive than employees who do not. In addition, there was a strong trend for exercisers to have fewer sick hours than nonexercisers. This was particularly true in the female and older worker populations. While this was a short-term study and therefore a casual relationship cannot be drawn, the company also noted that exercisers received less medical benefit reimbursement (females $637.07 and males $561.68) than nonexercisers (females $1,535.83 and males $1,003.07).

- At Control Data Corporation, sedentary individuals experienced claim costs that averaged $436 and .57 hospital days compared with $321 and .37 hospital days for the more active people.

- The Prudential Insurance Company reports that its physically fit employees took only 3.5 sick days a year as compared to 8.6 for the less fit employee. Prudential estimates that if all employee sick leave could be reduced to 3.5 days, a savings of $240,000 would be realized.

- A study examining the relationship between physical fitness and incidence of back injury in firefighters found that those firefighters classified as "least fit" demonstrated 10 times more back injuries than those classified as "most fit".

- A year of informal exercise for 120 Prudential Insurance Company employees demonstrated a reduction of their combined major medical claims by 37 percent, from $60,000 during the previous year to roughly $37,000 during the year that they exercised. Physical exams showed an overall increase in cardiovascular fitness among those who exercised, and participants also reported an improved ability to concentrate. The program cost approximately $120 per person to operate, and saved the company an average of about $353.

. Battelle Laboratories in Columbus, Ohio report that their physical fitness program decreased absenteeism of participating employees by 2.8 days, which Battelle calculates represents an annual savings in employee time of $150,000.

After experiencing 40 percent increases in health insurance costs in 1980 and 1981, Valmont Industries of Omaha, Nebraska joined the Wellness Council of the Midlands, which helped them set up a new health program in 1982. That year health costs rose only 4.1%, and in 1983 they actually declined by 2.6%.

. Mesa Petroleum in Amarillo, Texas reported that employees who participated in a corporate fitness program averaged $173 per person in medical costs, with 27 hours of sick time, whereas nonparticipants had $434 in medical costs and 44 hours of sick time.

. New York Telephone estimates an annual savings of $105,000 in absence and treatment costs for cardiovascular disease due to its exercise program.

. A recent investigation initiated by the Dallas-based Institute for Aerobics Research involved 7,400 teachers in the Dallas Independent School District. Fifty percent of the teachers were placed in a fitness program and were compared to their non-participating counterparts. It was found that teachers involved in the fitness project took an average of 3 fewer sick days per year, at a savings of $452,000 in substitute pay alone.

HYPERTENSION

- The number of employee deaths from high-blood-pressure-related cardiovascular disease is more than 10 times greater than the number of deaths from industrial accidents.

- There are almost 125,000 employee deaths a year because of cardiovascular disease related to high blood pressure.

- An estimated 30-million workers (more than one-third of the workforce) have either elevated blood pressure (140/90 mm Hg or greater) or take antihypertensive medication. Many of these workers are at increased risk of developing heart disease, stroke, and kidney disease.

- Only 20 to 30 percent of hypertensive employees have the condition adequately under control. Hypertension is an asymptomatic disease; many people are unaware they have it or do not think it is surious enough to warrant treatment.

- Those in the 45-74 age group have the greatest risk of developing hypertension.

- The direct economic costs of hypertension to employers include increased employee illnesses, accidents, and absenteeism, and decreased productivity, in addition to increased medical costs and disability and mortality rates.

- The average employee with high blood pressure costs a company between about $270 and $460 a year in lost output.

- Approximately 29 million work days, representing more than $2 billion in earnings, are lost each year because of hypertension, heart disease, and stroke.

- These illnesses are the primary cause of hospitalization, accounting for 7.5 percent of all physician office visits and six percent of all lost work days.

- As a group, white men between the ages of 45 and 54 lose annual earnings of $455 million from hypertension alone; black men in the same age group lose $32 million.

- Notably, worksite demonstration projects in hypertension management have achieved control rates of 68% to 78%, compared to overall rates of 31% throughout the general U.S. population. Furthermore, the third decade of life has the highest increase in hypertension incidence.

- A University of Michigan/Ford Motor Company study (1977-1981) showed that the average annual costs/employee for covered health services and disability payments were $564 for normotensive nonsmokers, $818 for normotensive smokers; $870 for hypertensive nonsmokers, and $1,3215 for hypertensive smokers. Each risk factor exerted a separate and independent effect on health care costs, with combined effects serving to double costs.

- A voluntary on-site (hypertension) screening, referral, and follow-up program at the home office of Massachusetts Mutual Life Insurance Company led to an increase in the percentage under control from 36 percent to 82 percent after one year of operation. The company saved $110 per year for each treated employee.

STRESS, EAP, & SUBSTANCE ABUSE

. Stress management programs have been shown in small studies to be associated with decreased absenteeism in some cases, increased self-reported productivity on the job and off the job, and reduced claims for somatic illnesses. However, the long term effects of different stress management activities have not been well studied.

. Equitable Life's stress management program, which provided individual counseling and biofeedback training to teach relaxation skills to people with serious stress problems or in high-risk categories had a cost benefit ratio of 1:$5.52 (for each dollar spent on treatment, the company saved $5.52).

. Results of New York Telephone's stress management program indicated a 10% decrease in absence for the 1,000 people who participated, at a savings for the company of $2,677/person just for decreased absence. The cost of the intervention was $300/person.

. The General Motors EAP reports decreases among program participants of 40 percent in lost time, 60 percent in sickness and accident benefits, and 50 percent in grievances. Kimberly Clark Corporation reports a 70 percent reduction in on-the-job accidents among its EAP participants.

. Estimates show that approximately ten percent of the employed population suffer some form of alcohol problem; only two percent of the workforce participate in existing employee assistance programs.

. A typical recreational alcohol/drug user is late three times more often than the average employee, uses three times the normal level of sick leave benefits, five times more likely to file work compensation claims, and 3.6 times more likely to be involved in an accident.

. A study at General Motors Atlanta Division substantiates that savings can be realized by providing treatment for employees who have substance abuse problems. It also demonstrates that there can be significantly more savings when employees participate in closely monitored, formally structured aftercare programs following substance abuse treatment, regardless of whether employees have problems with alcohol, drugs, or multiple substance abuse.

. A study at United Technologies demonstrated that day treatment for alcoholism can be a cost efficient and therapeutically effective alternative to inpatient treatment.

WEIGHT LOSS/NUTRITION

- Weight loss programs, using the best behavioral techniques, can achieve short and intermediate term success. Weight loss reduces risk of high blood pressure, hypercholesterolemia, Type 2 diabetes mellitus and some musculo-skeletal problems. the degree of long term success is, however, still unclear, even in clinical interventions. Within corporations, most weight management programs have a very high percentage of women enrollees. The most obese employees usually do not enroll. The combination of a weight management program with fitness activities can lead to effective longer term weight management.

- Approximately 16 million workers are 20 percent above desired weight; obesity increases the risk of cardiovascular disease, especially in combination with hypertension, elevated plasma cholesterol and diabetes.

- A group of New York Telephone employees successfully lowered their serum cholesterol levels through participation in a health nutrition program. These individuals also had a significant drop in body weight.

- Employees who are obese average $362.42 per year in health care costs as compared to normal weight employees who averaged $339.70. Hospital days of the obese averaged twice as many as the hospital days reported for the normal weight employees.

BACK INJURY

. New York Telephone employees trained in the YMCA's Healthy Back program experienced a cost saving of an estimated $302,000 a year in treatment and lost time.

. Burlington Industries is one example of a company that has shown tremendous success in preventing back injuries through careful screening and back care interventions.

Senator **Bumpers**. Thank you, Mr. Goldbeck.

Mr. Polk, who is your carrier?

Mr. **Polk**. Blue Cross-Blue Shield of Northern Ohio.

Senator **Bumpers**. Well how many people have offered to do business with you and how many people just wrote you nice letters? You came out reasonably well if you came out with Blue Cross-Blue Shield, did you not?

Mr. **Polk**. Well there are a couple of reasons I think why Blue Cross-Blue Shield has come to the fore. First of all, they are one of the few companies around that are required by state law to provide coverage to everybody under some circumstance, with some qualifications. And so it becomes more profitable for them to provide that kind of coverage in a managed care setting through COSE than it might be in the open marketplace.

The second reason is that we have been with them for a long, long time and they have had some history.

Increasingly we have seen preliminary offers from particularly HMO's and PPO's around town, but once they become aware of our requirements as an association for providing that care, such as you have got to be able to write, even with medical underwriting, a plan down to one insured, their zeal to do business with us abates substantially.

Senator **Bumpers**. Have you all considered self-insuring?

Mr. **Polk**. It is, because of Federal restrictions, not administratively feasible. I call your attention——

Senator **Bumpers**. What are the Federal restrictions?

Mr. **Polk**. It is not—there are some Federal restrictions. They would be, for example, if you take a look at the regulations that involve the 501(C)(9) trusts, voluntary employee benefits associations, for example. Those types of programs work very well for associations when those associations are homogeneous in their membership. In other words, if you are all metal stampers or you are all retailers, you can probably get away with establishing a (C)(9) trust for members of your association and their employees. However, given that COSE is an extremely broad based organization, we have members in every SIC code, I took the self-insurance idea to one of our law firms and after having looked at the situation for 6 weeks, even the most expensive law firm in town came to me and said we really do not think it would be a good investment on your part to have us investigate this still further. It would have required us, for reporting purposes, to have established under a single trust as many as a dozen to 18 sub-trusts, each of which would have to be separately administered and with 12 to 18 different lines of reporting both to the Federal Government, to the employer and to the employee. The administrative cost of such a program would have just been enormous.

Senator **Bumpers**. Ms. Maynard, do you not cover through your Alliance an employee or a dependent that has a pre-existing condition?

Ms. **Maynard**. In most cases the underwriting of the carrier that I support, the carrier that supports my program, yes they do not carry pre-existing, most of the pre-existing conditions.

Senator BUMPERS. Is this Alliance something you have put together to link all these people together and try to perform a service for them and make a little money out of it for yourself?

Ms. MAYNARD. Yes. Five years ago I identified the small business as having no purchasing power whatsoever. I come from a small town that is primarily geared to small business.

Senator BUMPERS. Where does your profit come from, how do you operate? You have eight employees you said?

Ms. MAYNARD. We have seven employees.

Senator BUMPERS. Seven employees.

Ms. MAYNARD. What we do is we charge $50 a year to join the association and we also have a newspaper that we provide——

Senator BUMPERS. Is that $50 a year per firm or per employee?

Ms. MAYNARD. Per firm. We will service any number of employees but we do have—the cutoff is usually six. If they do not want to go into a group of their own, then we keep them, we maintain them and we bill them—we assume all of the billing and all of the marketing for the program and at present I am paying about $400,000 a month in premiums to the carrier.

Senator BUMPERS. You are collecting and disbursing that amount?

Ms. MAYNARD. Exactly. And I process——

Senator BUMPERS. How many members do you have?

Ms. MAYNARD. Please?

Senator BUMPERS. How many members do you have?

Ms. MAYNARD. Members in the Alliance?

Senator BUMPERS. How many firms are in the Alliance?

Ms. MAYNARD. About 2,600.

Senator BUMPERS. Well is that $50 membership, is that your total income?

Ms. MAYNARD. That is it.

Senator BUMPERS. In other words, you just——

Ms. MAYNARD. We also have other, we run workshops for bookkeeping because the basic bookkeeping is not known—usually the basic shoe box is known in small businesses. So what we have done now is we have established workshops for the small business specifically geared for advertising and so forth, and we have our own newspaper that is a 30,000 publication, it's a predistribution mail to each member, but it is distributed throughout the State, which allows the members to advertise at a very inexpensive rate and again gives us revenue. So we have generated revenue from other avenues, therefore not having to kill the small business with a membership fee. So that a small—it does not matter if they are a sole proprietor. In fact, we have many fishermen, we have many insurance agents which would be independent people selling products, sales agents, we have many people who are independent, just sole proprietors. They join and they have access for their families and themselves to group rates.

Senator BUMPERS. So that is about $5 million a year. Who is your carrier?

Ms. MAYNARD. It is an HMO in Rhode Island. And they have been very flexible, however there have been problems because they also recognize somehow the small business person is a poor risk and I feel that small business people have—I know as far as my employees go, they are very seldom out of work. I have a very high retention of employees and I have very little sick time that I have to pay. The—usually the business owner gears himself towards health because he knows that if he is not at his job, that he will not have a business in a very short time. So I feel that they are not poor risks, maybe they drop dead within a shorter period of time. [Laughter.]

But that would be life insurance, that would not be health insurance. And I really would like to see statistics as to their claims, why are small business people so risky? It just does not make sense to me.

Senator **Bumpers**. Do you shop around for other carriers?

Ms. **Maynard**. Yes, unfortunately we only have two others. We have another HMO which is—I believe it is called a PIP, and we have one other one which would be Blue Cross and they have not been receptive to my organization, to my association of small business people.

Senator **Bumpers**. Well, why do you not get with Mr. Manley at Travelers and talk to him.

Ms. **Maynard**. I am presently investigating, in fact I am negotiating with two other companies for their health and their dental. And I did send a letter to Travelers, I have not heard—they did not answer me.

Voice: You will by next week.

Ms. **Maynard**. I will expect one shortly. [Laughter.]

Senator **Bumpers**. Well, I want to thank all of you for coming this morning. This hearing has been extremely helpful to me. I think it is reasonable to conclude from all of the testimony this morning that we have a critical problem but that mandated coverage is not something that is going to solve it. Obviously people would rather have a job with no coverage than no job with no coverage and it seems to me that that is sort of what we are down to. It does seem that some of you have done very innovative and creative things that ought to be a matrix for somebody else.

Yes, Mr. Goldbeck?

Mr. **Goldbeck**. One comment that would be consistent with Senator Weicker's interest in research. We were asked about what was the increased cost resulting from the State mandates. If in fact it is 10 percent—that is what he—the witness from Travelers—said the first time and then when you asked him again he said 6 to 15 percent—so if that is the range, somebody really ought to do a cost-effectiveness assessment. It is well within the purview of Congress—in fact right within your committee—to request of any number of agencies to find out what that 10 percent add-on in cost, which is much less than I think many people would have expected the answer to be—produces for us in health. If it produces a 15 percent or a 30 percent gain in health over a lot of years, then we ought to find a better reply than saying we do not like State mandates. And, if there is no gain in health, the mandates should end. But we do not know right now. There is a knowledge gap on that fact that would be very valuable if this committee could plug.

Senator **Bumpers**. Ms. Maynard, there is one question that I have that I just thought of on this—what do you call it, TID or TDI?

Ms. **Maynard**. TDI, Temporary Disability Insurance.

Senator **Bumpers**. And does every employee in Rhode Island contribute one percent of his salary—

Ms. **Maynard**. Yes, every working person, part time as well as full time.

Senator **Bumpers**. And that—is that the same thing as unemployment compensation or is that for some other purpose?

Ms. **Maynard**. Yes, it is similar, only it comes into effect when you are sick, it is for—

Senator **Bumpers**. Why do we not have such a plan as that say for catastrophic illness so that the Blues did not have to offer high option and all—

Ms. **Maynard**. You just hit the key—exactly. It would considerably reduce the premiums because now each insurance carrier would realize that the max they would be responsible for would be $35,000 or $40,000 worth of it on you, on each individual. So if you began to lock their commitment in, there is no reason why they should not reduce their rates considerably. So I believe—

Senator **Bumpers**. If you notice they are always reluctant to do that under any circumstances.

[Laughter.]

Ms. **Maynard**. Well we will not—

Senator **Bumpers**. That would be like trying to cut Congressional pay.

[Laughter.]

Ms. **Maynard**. But I really feel that it should be investigated. I feel that it is the key and I do not think that it would even be one percent of each employee, because the odds of someone being sick and needing temporary disability are much greater than the odds of someone having a catastrophic illness. And also the catastrophic coverage would have to be considered for families, so that if I were employed and I wished the family to be covered because I am the sole owner, then I would pay a little more for the two children that I have. However, only one income earner would have to pay for the family and if we mandate, now you have got a problem of which one is going to have the family coverage and which employer is not and who is going to pay for the residual coverage and who is going to be double-coveraged and so forth. It would be employee controlled and I feel that is very important because it is the employee we are concerned with presently.

Senator **Bumpers**. I will just close on this note, catastrophic illness is very sexy and trendy to this country right now, but defining what is catastrophic and what is not is quite a chore. It is well nigh irresistible for hospitals not to—what shall I say—make catastrophic illnesses if they have an occupancy rate of 50 percent. They are going to create—they are pretty innovative about creating catastrophic conditions, determining what is catastrophic and what is not. Those are all really problems that we have not addressed and will have to be addressed.

Thank you all very much for coming. The Committee is in recess.

[Whereupon, at 12:27 p.m., the hearing was recessed.]

APPENDIX

/From the National Journal, March 14, 1987/

INCOME SECURITY REPORT

Kennedy's New Tack

Backing away from his old campaign for government-run national health insurance, Sen. Edward M. Kennedy proposes a bill to require employer-paid coverage.

BY JULIE KOSTERLITZ

Even before he took the chair of the Labor and Human Resources Committee, Sen. Edward M. Kennedy, D-Mass., made it clear he intended to be a man of action. After all, he wasn't giving up the arguably more glamorous opportunity to lead the Judiciary Committee without a reason.

In early February, Kennedy made good on his promise to shake up the status quo. "The time has come," he told an American Hospital Association (AHA) gathering, "to require all businesses in America to offer health insurance to all their workers—and all their dependents, too—as a condition of doing business." Within weeks, he circulated the outlines of a major bill he plans to introduce this spring.

There was a certain irony to the proposal. Kennedy had bitterly opposed the idea when it was offered as part of a national health insurance plan in mid-1979 by then-Health, Education and Welfare Secretary Joseph A. Califano Jr. because Kennedy then favored a full-scale, government-run national health insurance scheme. "He blasted it, as did the labor unions," Califano said of the idea.

But this year, when Califano again pitched the idea in private talks with Kennedy in January, Kennedy was receptive. "I teased him," said Califano, now a senior partner in the Washington office of the New York law firm of Dewey, Ballantine, Bushby, Palmer & Wood. "I told him I was glad he finally came around."

The turnaround may be less a reflection of change in Kennedy's philosophy than in the political and economic climate. With federal dollars in short supply, Congress in the past two years has grown increasingly bold about considering legislation that asks employers to meet societal demands that the federal government has decided it can't afford.

Much to business's chagrin, Congress has already passed legislation requiring employers to continue paid health insurance for laid-off workers at the workers' own expense and may require employers to provide unpaid leave to parents of sick children.

Kennedy's proposal goes far beyond other recent efforts. "There's no question that mandatory health insurance has far broader implications, in terms of cost and the numbers affected," said Fred Feinstein, staff director and counsel of the House Education and Labor Subcommittee on Labor-Management Relations. As labor legislation, the bill rivals the establishment of the minimum wage law; as health legislation, it could provide more direct health coverage than any single law since the creation of the medicare program more than two decades ago.

The significance of Kennedy's bill is tied to a fact not widely appreciated: While most Americans have health insurance, and while most of them get it through the workplace, the largest single group of those without insurance are working men and women and their dependents. Of about 35 million Americans who weren't covered by health insurance in 1985, more than 86 per cent lived in families with a working head of household. More than two-thirds lived in households whose heads worked full-time and year-round. *(See table, p. 611.)*

While there is some dispute over Kennedy's assertion that three-fourths of workers without insurance work in firms with 25 or fewer employees, not even small-business lobbyists dispute the implications of the numbers. "He's put his finger on the coverage gap, there's no doubt about it," said John J. Motley, director of federal governmental relations at the National Federation of Independent Business (NFIB), an association of small employers.

The working poor are among those who get medical care at low-cost clinics.

But, Motley contends, there's a simple reason for the lack of coverage: Small business "can't afford it." Kennedy's bill includes a special provision to help small business get relief from the relatively high rates they face now, but Motley said that wouldn't be enough.

Forcing small employers to offer insurance, say small-business advocates, could exact its own toll in higher prices, lower wages, more business failures and fewer jobs. Some economists agree. "It reduces employment, no question," said Daniel S. Hamermesh, a professor of economics at Michigan State University in Lansing.

Persuasive as the cries of thousands of small, hometown enterprises usually are on Capitol Hill, Congress might not be swayed this time. As the number of uninsured persons has grown, pressure has mounted on Capitol Hill to take action.

While organized labor is the only major force that is openly supporting Kennedy's concept, there is widespread sympathy for it in what might seem unlikely quarters—hospital groups, doctors, the insurance industry and even some large employers already offering health insurance. While few are likely to openly endorse a new government intrusion into the private sector, these groups are keenly concerned about being forced to absorb the costs of medical care for those who lack insurance.

Richard A. Bloom

Lobbyist John J. Motley
Small business can't afford it.

CHANGES IN COVERAGE

How many Americans lack health insurance is a matter of debate. Katharine Swartz, a senior research associate at the Urban Institute, says Census Bureau data show that about 37 million individuals had no health insurance in 1986, and that figure is widely cited by Members of Congress.

Gail R. Wilensky, vice president of health affairs at Project Hope, argues that the census data aren't reliable for health coverage calculations, and she puts the number at closer to 31 million. But no one disagrees that there is an upward trend in the number, which six years ago was estimated at 28 million.

Behind the rapid growth, experts say, are two major problems: the declining scope of medicaid, the joint federal-state health program for the poor, and changes in the job market.

Tighter federal eligibility requirements reduced the number of medicaid participants, while state income limits for would-be recipients failed to keep pace with inflation. As a result, medicaid coverage of low-income individuals dropped from 63 per cent in 1975 to 50 per cent in 1985. The trend may be reversing because Congress and some states have moved in recent years to expand eligibility for some groups.

Calculating the impact of changes in the workplace is more a matter of surmise than of looking at hard data. The economic recovery of the past few years hasn't stemmed the growth in the number of uninsured, according to a common argument, because a growing share of new jobs is in the service sector, where wages are generally lower and benefits are less widespread than in heavy industry. Growth in part-time employment, which usually doesn't provide health benefits, may have added to the problem.

There's disagreement over how important these trends have been, but an analysis by the Employee Benefit Research Institute shows that 75 per cent of workers without health insurance earned less than $10,000 a year. "The more you get into it, the more clear it is [that] these are low-earning workers," said Deborah J. Chollet, a senior research associate at the institute.

The growing number of uninsured might have been cause enough for Congress to evince concern. But as cost pressures forced the government and big private insurers to watch what they spent on health care, the question of who pays for those without public or private insurance has taken on more importance. Hospitals and doctors providing care to the uninsured have increasingly found themselves unable to pass along those costs. In 1985, the nation's hospitals reported giving nearly $6.3 billion worth of care for which they were not paid; the burden has fallen most heavily on the nation's already strained public hospitals. *(See NJ, 11/24/84, p. 2245.)*

With large infusions of federal cash a political impossibility, state and federal lawmakers have looked for ways to spread the burden among various private-sector parties that could pay. About 10 states have set up "risk pools" for those unable to get private health insurance for medical reasons—a relatively small share of the uninsured. The plans are typically financed by surcharges on private insurance plans, but are prohibited by a quirk of federal law from charging the growing number of large firms that finance their own employee health plans rather than buying commercial insurance. *(See NJ, 12/21/85, p. 2913.)*

A few states might allow other persons without insurance to buy into these risk pools, but the premiums tend to be so costly that participation is limited. A handful of states try to spread the costs of some hospitals' bad debts and charity care among all hospitals. Opponents have been able to kill proposals in some states to tax hospital revenues, saying that would be a tax on the sick.

Congress has also gotten into the act:

- A bill that would have required states to set up risk pools, including self-insured plans, passed the House last year as part of the fiscal 1987 budget reconciliation package. Senate-House conferees, after wrangling over whether participation should be mandatory, allowed the measure to die in conference. Rep. Barbara B. Kennelly, D-Conn., the prime sponsor, plans to reintroduce the bill this year.
- A bill pushed by Kennedy and Rep. Fortney H. (Pete) Stark, D-Calif., to require employers to allow laid-off workers and their families to extend their old health insurance at the workers' expense was enacted last year as part of the fiscal 1986 reconciliation package. An attempt to extend employer-paid health insurance to that group was dropped from the fiscal 1987 reconciliation bill in conference late last year.
- A House committee approved a bill last year to require employers to offer up to 18 weeks of unpaid leave with continued health benefits over a two-year pe-

riod for parents who adopt newborn children or care for seriously ill children or parents. The bill, which would also allow up to 26 weeks of unpaid medical leave for workers with serious temporary disability, including pregnancy, didn't make it to the floor, but has been reintroduced this year.

ORDER OF MAGNITUDE

Employers are hardly enamored of this trend. The prospect of being forced into state-run risk pools is perhaps a minor annoyance, given the limited scope of such pools. Requiring them to provide unpaid medical and parental leave has raised more hackles. The Chamber of Commerce of the United States says such legislation could cost employers heavily because they would be required to continue paying health insurance costs for employees on leave and to find replacements. The additional costs, the chamber argues, could hurt the ability of U.S. firms to compete in international markets.

But the Kennedy proposal represents a new order of magnitude. "Compared with this, [the parental and medical leave bill] is a relatively minor piece of legislation," Feinstein said. While many details remained to be worked out, in broad outline the Kennedy bill would amend the Fair Labor Standards Act or the Public Health Service Act to require that all employers, except a handful not subject to minimum wage laws, provide a minimum health insurance package to full-time employees and their dependents.

The plan, which employees would be required to accept, would include basic hospital and physician care, diagnostic tests, prenatal care, infant care and preventive care for children, and would set a limit of $2,000 on a patient's total out-of-pocket expenses for all covered services. Employers would have to pay at least 80 per cent of the premiums. Workers' deductibles would be limited to $150 for an individual and $300 for a family, and workers' payments for medical services couldn't exceed 20 per cent of each medical bill.

While the proposal initially included all those working at least 17.5 hours a week—the same definition of full-time workers used in the tax code--Kennedy aides hinted that the issue of part-time workers was a sensitive one. They suggested that if the definition was too strict, it could discourage employers from hiring more part-time workers; if too lenient, it could encourage employers to downgrade their full-time workers to part-time status as a way of circumventing the law.

Richard A. Bloom

Benefits expert Deborah Chollet
"These are low-earning workers."

Behind the proposal is Kennedy's belief that meeting societal needs is a legitimate price for those profiting in the marketplace. "Just as workers are entitled to be paid a minimum wage by their employers, so they should be entitled to health insurance on the job," Kennedy said in a speech to the United Auto Workers in mid-February. By building on the private system, he argues, his proposal is less onerous than national health insurance. And requiring all businesses to participate, he says, is more equitable than the current system, in which the health costs of the uninsured are spread haphazardly. "It is time to place these costs on the shoulders of the relatively small numbers of firms who refuse to protect their workers," he told the AHA.

For all the tough talk, Kennedy attempts to address some of small business's objections. Because they incur higher per-person administrative costs and have a smaller pool of individuals over which to spread the risks of high-cost illnesses, small businesses have traditionally paid premiums averaging 40 per cent more than large employers pay—when insurance is available. He may propose that all businesses with 25 or fewer workers be required to join a new regional or statewide pool that would purchase insurance as a group—thereby spreading risks and administrative costs. Employers would be able to buy one of several plans, ranging from the minimum required to more generous packages, from insurance companies chosen through competitive bidding. Health maintenance plans that met certain conditions could also be offered. The new system would be overseen by the Health and Human Services Secretary.

To address fears that minimum requirements would balloon under state laws requiring inclusion of extra services, Kennedy's proposal would preempt state coverage requirements. And to address fears that the federal government could expand the package at whim, it specifies that no new services could be added unless also required under the joint federal-state medicaid program.

Because owners of unincorporated small businesses—including self-employed individuals—can't deduct the full costs of their own health insurance, they lack an incentive to provide it for employees as well. Thanks to the tax reform law passed last year, such business owners will be able to deduct 25 per cent of their health insurance costs. Kennedy proposes to increase their deduction to 100 per cent, but that proposal would be separate to avoid having to subject the broader plan to approval by the tax-writing committees.

While small-business representatives generally oppose Kennedy's initiative, a few find some comfort in the idea of pooling risks among small businesses. "If Congress mandates health coverage without adjusting the underlying problem of availability and affordability, it will be doing a great disservice to Mom and Pop enterprises," said Francis R. Carroll, president of the for-profit Small Business Service Bureau in Worcester, Mass., which offers its 35,000 members lower-cost insurance by pooling risks.

OVER THE EDGE?

Despite his overtures, Kennedy is unlikely to avoid the wrath of small businesses everywhere. While some small-business representatives offered suggestions on his bill at a meeting in late February called by Kennedy and Sen. Lowell P. Weicker Jr., R-Conn., they warned that most small businesses would fight it tooth and nail. "It's different for those of us inside the [Washington] beltway," said the NFIB's Motley, "but these people who have started and run small businesses believe the government has no business telling them to do this. They don't believe in the minimum wage. They believe in free enterprise. We all laugh, because it sounds rash, but to a small-business owner in Idaho, Southern California or the woods of Maine, that's what they believe."

The federal government, small-business advocates contend, should find incentives to entice rather than force employers to offer health coverage. The government could, for example, help promote greater participation in private risk-pooling plans. They also applaud the proposed 100 per cent tax deduction but argue it won't help the many small businesses with few or no profits.

Government mandates ruin employers' flexibility and preempt workers' choices about what kinds of benefits they want, some argue. What happens, Wilensky asks, in a small office where three women have coverage through their spouses' health insurance and would rather have more cash than a health plan, while a fourth has no other coverage? Some employees prefer the cash, say employers. "The most important employee benefit is a paycheck," Cynthia Grantz, president of Illinois-based Rockford Coatings Corp., testified at a recent hearing on the parental leave bill.

Small-business representatives argue that their sector creates the most new jobs but is a fragile arena in which 20 per cent of all new enterprises fold within a year and most of those that survive don't turn a profit for at least 18 months. Kennedy "thinks they're all chic high-tech firms like the ones around [Route 128 near] Boston," Motley said. "We're talking about the dry cleaners, the sandwich makers, the hairdressers." Health benefits, they note, represent no small piece of change. A recent survey by the Chamber of Commerce of 1,000 firms found that health benefits averaged more than 5.6 per cent of payroll costs. For small firms with low-wage workers, that figure could be much higher, Chollet argues.

A recent survey of 1,500 firms by the New York insurance brokerage firm of Johnson & Higgins found health-benefit costs averaging about $1,900 a year per employee. "If you're only paying workers $10,000 a year, even if your health benefit costs are only $1,200, you're still raising compensation by 12 per cent a year," she said. Kennedy's plan, critics say, could push some companies over the edge.

The notion that small businesses could absorb the costs without ill effect, Hamermesh of Michigan State said, is valid "only if you believe that there's a lot of fat in these businesses. I don't believe that." The costs, he said, "will come out of wages, or out of something else [such as] not hiring other workers or a reduction in the number of firms operating. Some workers will keep their jobs and do real well, and others won't have or get jobs."

Hamermesh said it would make more sense to set up a national health insurance system underwritten by general revenues, but he conceded that the chances of such a program becoming law are slim. While Kennedy's plan would risk some increase in unemployment, he said, "Maybe that's a price we want to pay."

BOTTOM LINE

That, of course, will depend on how the political opposition shapes up. While few believe the measure could pass this year, there are signs of political interest in a number of quarters. The House Education and Labor Committee plans to offer a companion bill, and the Small Business Committees in both chambers will probably hold oversight hearings.

There are rumblings of opposition from some Members. Sen. Dan Quayle, R-Ind., recently sought, unsuccessfully, to amend the Labor and Human Resources Committee's rules to set a dollar limit on the costs imposed on employers by committee legislation.

Outside of Congress, the NFIB and the Chamber of Commerce are already alerting their members, and the recently formed Concerned Alliance of Responsible Employers (CARE) also expects to weigh in. Its 140-odd members include K mart Corp., General Motors Corp. and trade groups for distributors, retailers and manufacturers. Grass-roots opposition, they say, would be formidable. "You'd be getting every restaurant, gas station, dry cleaner and beautician upset," said Motley.

The positions of other key players are less clear. Although opposed to government mandates, hospital and physician groups are deeply concerned about the costs of uncompensated care left on their doorsteps and the unpalatable prospect of turning patients away. "The AHA looks at mandated coverage as a last resort," said AHA director of communications Clay Mickel. And the American Medical Association (AMA) hints that it, too, is open to the idea. "We tend historically to rely more on incentives than mandates," said Wayne Bradley, the AMA's vice president of public affairs. "While it's an important difference, it's not fatal," he said.

The AFL-CIO executive council quickly endorsed Kennedy's idea at its annual winter gathering in Bal Harbour, Fla. The labor federation sees its support as an extension of its longtime advocacy of national health insurance, but concedes there might also be a practical dividend. "If the nonunion employer does not provide health care and the unionized employer recognizes its social obligation and does, the nonunion employer has a competitive advantage," said Bert Seidman, director of the AFL-CIO's department of occupational safety, health and social security.

Perhaps the pivotal players are large employers. Most of them already meet or surpass the proposed insurance requirements, and many complain they're indirectly subsidizing those who don't offer insurance. But James A. Klein, the chamber's manager of pension and employment benefits, said its members are solidly against the bill. "We really don't view this as a matter of large versus small," he said. "Though most large employers already provide this [health insurance], they have concerns about the mandated approach."

The Business Roundtable, which represents *Fortune* 500 firms, has yet to declare its position, but an organization insider said its expected opposition "will be token at best." And Califano, who helped Chrysler Corp. streamline its costly health insurance program, thinks big-business support is inevitable. "My experience in Washington is that when major economic interests choose between philosophy and the bottom line," he said, "they tend to choose the bottom line." ☐

Living Without Insurance

Workers and their families accounted for the vast majority of the 34.8 million Americans under age 65 lacking health insurance in 1985, according to an analysis of Census Bureau data by the Employee Benefit Research Institute.

Employment status of household head	**Number of uninsured (millions)**	**Percentage of uninsured**
Full-year, full-time	24.2	69.5%
Full-year, part-time	2.8	8.0
Part-year worker	3.2	9.2
Nonworker	4.7	13.5

National Federation of
Independent Business

[illegible]

NFIB

STATEMENT OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Submitted to:	Senate Small Business Committee
Subject:	The Cost and Availability of Health Care Benefits for Small Businesses
Date:	April 23, 1987

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INTRODUCTION

Mr. Chairman, on behalf of the National Federation of Independent Business and its more than 500,000 small business owner members, we appreciate the opportunity to participate in this committee's investigation into the cost and availability of health care benefits for small business. The lack of availability of health care insurance is surely one of the barriers to health care. Small employers are increasingly reducing this barrier to adequate health care for themselves and their employers by providing employment-based health insurance plans. Yet many policy makers, in their desire to make health insurance available to everyone, are in danger of creating new barriers to health care by imposing unrealistic requirements on small employers which will force them to drop existing health insurance plans. Without recognizing what the trends are in voluntary employee benefits and without recognizing what profitability and labor market realities face small employers, policy makers' good intentions may become the next, and biggest, barrier to adequate health care. Consequently, our testimony focuses on employer-provided health insurance and on proposals to federally mandate health coverage.

In brief, we will argue that for the very large majority of small business owners in America, market forces ought to be allowed to operate in this product area. The goals of affordability, product quality, and broad coverage can best be ensured by insurance industry competition and informed consumer choice. The government should take the considerable role of ensuring that both of these conditions are met in our society. It is our hope that our testimony will both discourage overbearing government intervention and foster insurance industry competition, since the bulk of our statement consists of what might be called a small business market survey. If, however, public policy dictates that the government involve itself in the provision of health insurance, our testimony provides guidelines for making that involvement more effective and less expensive than it otherwise might be, at least as far as small employers are concerned.

The National Federation of Independent Business is a voluntary membership organization comprised of more than 500,000 small business owner members. NFIB is primarily an advocacy organization, and our focus is primarily legislative. We represent the views of our members in the state capitals of all 50 states as well as before the federal government.

NFIB polls its entire membership to establish our position on public policy issues. The majority vote of the respondents becomes the position of NFIB. In addition, on issues of great complexity and/or interest to our members, we conduct much more sophisticated and indepth surveys of our membership. Such surveys are recognized by the Small Business Administration and others as valid surveys of the small business community in general*.

* William C. Dunkelberg and Jonathan A. Scott, Report on the Representatives of the National Federation of Independent Business Sample of Small Firms in the United States, Small Business Administration, 1984.

The following chart provides one indicator of why this is the case:

Profile of Small Business

	NFIB Membership by Industry	National Small Business Population by Industry
Retail	30%	31%
Service	28%	29%
Wholesale	8%	11%
Total Non-capital intensive	66%	71%
Manufacturing	13%	10%
Construction	13%	12%
Agriculture	5%	2%
Transportation	3%	4%
Total capital intensive	34%	28%

What follows in the next section of this testimony is based upon two such surveys. One, conducted in late 1978, is entitled National Health Insurance Report on Small Business; the other is entitled Small Business Employee Benefits, and was conducted in the latter part of 1985. The concluding part of this testimony is a discussion of the public policy recommendations NFIB would make based on the above material and our public policy polling results. As Appendix A we have included polling results in this area over the last ten years.

HEALTH INSURANCE AND SMALL BUSINESS.**

Sixty-five (65) percent of surveyed small business owners provided health insurance for at least a portion of their full-time employees. Approximately two-thirds (42%) carried it for all and one-third (23%) carried it for some. Provision was directly related to firm size--the larger the firm, the more likely it was to have employee health insurance. This relationship is clear whether firm size is measured in terms of employees (Table 2) or annual gross receipts (Table 3).

** See Appendix B on how the survey was conducted.

Table 1
PERCENT OF SMALL BUSINESSES PROVIDING SELECTED TYPES OF EMPLOYEE BENEFITS BY BENEFIT TYPE AND PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM

	PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM					
EMPLOYEE BENEFIT	None+	1-39%	40-60%	61-99%	100%	Total
Health Insurance	36	8	5	10	42	100%
Dental Insurance	84	2	1	2	11	100%
Retirement Plan	74	3	2	4	18	100%
Paid Vacations	23	7	3	8	59	100%
Paid Sick Leave	52	7	3	4	34	100%
Long-Term Disability	80	3	2	3	12	100%
Life Insurance	51	6	4	6	33	100%
Education Assistance	77	6	1	3	13	100%
Employee Discounts	61	2	2	3	32	100%
Flex-Time	82	8	3	2	7	100%
Paid Lunch Break	75	4	2	2	18	100%
Dependent Care	95	1	*	1	3	100%2Legal
Assistance	97	1	1	*	2	100%

Number of Respondents = 1,439

+ includes no answer
* less than 0.5%

+/ No answers can reasonably be interpreted as a random phenomenon or as a negative response. The former interpretation leads to distributing non-respondents proportionally across all answers; the latter interpretation leads to adding non-respondents to the negative column. The negative response interpretation was selected after reviewing individual questionnaires. It was evident from those documents that the intention of most non-respondents was to indicate a negative answer.

Table 2

PERCENT OF SMALL BUSINESSES PROVIDING THE MOST COMMONLY PROVIDED EMPLOYEE BENEFITS BY COMMON BENEFIT TYPE AND FIRM SIZE

	FIRM SIZE (FULL-TIME EMPLOYEES)							
MOST COMMON BENEFITS	1-4	5-9	10-19	20-49	50-99	100+	No Answer	Total
Paid Vacations								
Provided All	55	69	70	66	70	85	21	59%
Provided	18	18	22	27	29	16	5	18%
Not Provided	27	13	8	7	2	*	74	23%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Health Insurance								
Provided All	32	51	54	54	58	74	14	42%
Provided	17	28	29	34	36	15	9	23%
Not Provided	51	20	17	12	7	10	77	36%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Paid Sick Leave								
Provided All	35	37	38	36	32	49	12	34%
Provided	11	12	19	22	36	21	5	14%
Not Provided	54	51	43	42	32	31	83	52%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Life Insurance								
Provided All	21	39	46	41	56	80	14	33%
Provided	9	17	23	30	36	21	3	16%
Not Provided	70	44	30	29	9	*	83	52%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Employee Discounts								
Provided All	35	36	33	31	20	36	17	32%
Provided	7	6	10	8	12	3	5	7%
Not Provided	59	59	58	60	68	62	78	61%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Retirement Plan								
Provided All	9	16	28	31	54	56	6	18%
Provided	5	9	11	13	20	13	3	8%
Not Provided	86	76	61	57	26	31	91	74%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Number of Resp.	534	299	209	144	59	39	155	1439

* less than 0.5

Table 3

ANNUAL GROSS RECEIPTS OF SMALL BUSINESSES BY PERCENT OF FULL-TIME EMPLOYEES COVERED WITH EMPLOYER PROVIDED HEALTH INSURANCE (in percent)

ANNUAL GROSS RECEIPTS ($000's)	PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM None+	1-39%	40-60%	61-99%	100%	Total
Less than 100	81	4	1	2	12	100%
100-199	59	7	5	7	23	100%
200-499	40	10	4	9	38	100%
500-799	26	10	4	13	47	100%
800-1,499	19	8	6	17	51	100%
1,500-2,999	8	7	8	14	63	100%
3,000-4,999	10	11	9	9	62	100%
5,000-9,999	11	4	4	13	70	100%
10,000 or More	6	4	4	17	70	100%
No Answer	38	8	6	9	40	100%
Percent of Respondents	36%	8%	5%	10%	42%	100%
Number of Respondents	517	110	66	149	597	1439

+ includes no answer

Benefits and Conditions

Hospitalization/surgical insurance covers those components of health care provided by a hospital and the "usual, customary, and reasonable" charges for surgical procedures performed. Major medical covers expenses beyond basic hospital and surgical benefits. A form of major medical known as comprehensive consists of major medical coverage "plus." These are the general types of health insurance (excluding such additions as dental) from which small employers can choose. Unfortunately, the comprehensive variation was inadvertently omitted from the questionnaire, limiting somewhat the analysis that could be performed on types of health insurance purchased by small business owners.

Over 80% of all respondents with health insurance reported carrying the most comprehensive benefit coverage listed on the survey, i.e. hospitalization/surgical and major medical (Table 4). Just 8% provided lesser coverage, and 10% either didn't reply or didn't know. There was some evidence that smaller firms were more likely to provide lesser kinds of coverage and vice versa, but the relationship was surprisingly weak.

Approximately one-third of those with health insurance did not provide it to all full-time employees. ("Non-discrimination" rules allow different benefits or levels of benefits to be provided to different employee groups under specified conditions.) Table 5 reviews the conditions upon which some full-time employees were excluded from the plan. In almost half of the cases, a specified number of years on the job was the basis for inclusion/exclusion. (Later, the relationship between employee turnover and coverage will be visited.) Level of responsibility was the second most frequent point of distinction.

Eighty-six (86) percent provided an option for dependent coverage; just 3% indicated no dependent coverage was available. Those without dependent coverage tended to be among the smaller firms and vice versa. However, in no size class did the dependent coverage option fall below 74%. Only 8% of those carrying insurance provided part-time employees with the same health benefits as provided full-time employees. Virtually none provided a reduced level of coverage for part-time employees, illustrating the impracticality for most small businesses of carrying more than one coverage. Given the fact that 18% had no part-time employees, the number covered was actually higher than 8%. However, it is clear that comparatively few part-time employees working in small businesses received employer-sponsored health insurance benefits.

While the survey could not obtain more specific data on the level of health insurance provided, it appeared that once offered, the quality of insurance provided was reasonably uniform. There seemed to be little progression in benefit levels. In other words, a small business apparently did not initially offer minimal coverage, e.g., hospitalization only, then move toward a better plan for benefit progression. Rather inclusion and exclusion of employees appeared to substitute. Though further evidence will be needed to confirm (or refute) this observation, temporarily assuming its accuracy, the second order question quickly becomes whether the employer decision is purposeful or whether insurance pricing is structured to force the decision.

Table 4
TYPE OF HEALTH INSURANCE PROVIDED SMALL BUSINESS EMPLOYEES
BY ANNUAL GROSS RECEIPTS OF SMALL BUSINESSES
(in percent)

	ANNUAL GROSS RECEIPTS ($000's)						
INSURANCE TYPE	Under 200	200-799	800-1,499	1,500-4,999	5,000 or More	No Answer	Total
Hospitalization/ Surgical	2	4	4	2	2	3	3%
Major Medical	8	4	6	5	4	6	5%
Hospitalization/ Surgical and Major Medical	78	79	80	88	88	76	82%
Don't Know/No Answer	13	13	10	6	10	15	10%
Total	100%	100%	100%	100%	100%	100%	100%
Number of Resp.	120	312	159	198	100	33	922

NA A few large small businesses reported both voluntary and compulsory benefit levels that were considerably "out-of-range." While there is no question of the data's authenticity, additional work is required before they can be reported. Until then, the maximum allowable cost for purposes of calculating an all firms average is $9,999 per month.

Table 5

SELECTED CONDITIONS OF EMPLOYEE HEALTH
INSURANCE COVERAGE BY INDUSTRY
(in percent)

SELECTED CONDITIONS	INDUSTRY										
	Con	Mfg	Trn	Whl	Ret	Agr	Fin	Ser	Prf	N/A	Tota
Basis for Coverage+											
Years on the Job	22	13	11	6	15	28	6	14	9	29	14
Certain Wage or Salary Level	3	2	3	2	4	6	*	7	*	14	3
Age	*	2	*	1	2	3	3	3	*	14	2
Level of Responsibility	8	4	11	5	10	14	3	7	3	43	7
Other	7	3	8	5	4	*	10	8	5	*	5
None	60	76	67	81	65	49	78	61	83	*	69
Option for Dependent Coverage											
Yes	86	92	87	89	82	72	91	79	91	86	86
No	1	1	*	2	6	11	1	7	5	*	3
No Answer	13	7	13	9	12	17	7	14	5	14	11
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100
Part-Time Employee Coverage											
No Part-Time Employees	32	23	32	17	9	11	16	22	11	14	18
No Coverage	27	41	32	42	46	50	30	46	41	57	40
Less Coverage Than Full-Time	*	3	*	2	1	*	*	1	*	*	1
Same Coverage As Full-Time	8	4	3	6	10	8	10	9	20	*	8
No Answer	34	30	34	34	35	31	44	22	29	29	33
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100
Number of Resp.	120	155	38	103	226	36	81	90	66	7	922

+respondent could mark more than one answer
* less than 0.5%
N/A no answer

Trends in Coverage

Health insurance coverage appears to be increasing in the nation's small businesses, though the proportion of small business employees covered remains significantly less than the proportion covered in large and mid-sized enterprises. The 65% of responding small business owners now reporting at least some full-time employee coverage (See Table 2) represented an eight percentage point increase from 1978 when a similar survey reported 57% coverage.[*/] The retail, finance, and professional services industries were largely responsible for the rise (Table 6). All three industries experienced increases from the 1978 survey of more than 10 percentage points. Transportation/Communication also appeared to have experienced a considerable increase, but the sector's small sample size (n=37 and n=53) allowed no conclusions. The troubled agricultural industry was the only sector which reduced coverage over the period.

Since the retail, finance, and professional service industries tend to consist of firms smaller than average, the increased number of firms now providing employee health insurance can also be tied to greater coverage among smaller firms. Unfortunately, a direct comparison of coverage by firm size as measured in annual gross receipts is almost meaningless. With the Consumer Price Index having risen by 66% over the period, inflation has changed the value of a specified level of gross too much to compare response classes. However, it can be observed that the largest firms were no more inclined to provide health insurance in 1985 than they were in 1978, and perhaps even a little less. By elimination, the smallest firms then were those left to account for the greater coverage.

The overall quality of health insurance plans, i.e. coverages, costs, deductibles, etc. appeared to have also changed. Unfortunately, a comparison between quantity (number with plans) and quality (composition of plans) is difficult at best, but it is exacerbated by the data available. Quantity for present purposes was measured over a seven-year interval employing two different surveys. Quality was measured over a three-year interval employing one survey and the recall of respondents. Complicating matters, changes in the first four years were probably significantly different from those in the last three.

Despite these data limitations, small business owner responses in 1985 suggested considerable change in the characteristics of health benefits provided over the past three years, though on balance only modest improvement (Table 7). For example, the number increasing the percentage of employees covered was three times as great as the percentage decreasing. Benefits were increased by 26% compared to 14% reducing them. But the size of deductibles rose in 38% of the cases; co-insurance requirements rose as well. Costs (premiums) for both employers and employees rose, but employers were far more likely to have

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[*/] National Health Insurance Report for Small Business (National Federal of Independent Business: San Mateo, CA), June, 1978.

experienced one. In fact, three of four reported their premium cost higher than three years prior, but just one of four reported the employee premium cost higher. As many as 36% failed to respond to aspects of change in health insurance coverage. Since only responses from those with coverage three years ago were counted, it would appear that many owners were not familiar with the details of the plan they provide.

Table 6

PERCENT OF SMALL BUSINESSES PROVIDING
EMPLOYEE HEALTH INSURANCE BY
INDUSTRY - 1978 AND 1985

	YEAR		PERCENT CHANGE
INDUSTRY	1978	1985	1978-1985
Construction	66	73	+11
Manufacturing	81	83	+2
Transportation	60	73	+22
Wholesale	73	73	0
Retail	46	58	+26
Agriculture	52	48	-8
Financial Services	56	65	+16
Services	48	52	+8
Professional Services	49	62	+27
ALL FIRMS	57%	65%	+14

Table 7

PERCENT OF SMALL BUSINESSES EXPERIENCING
CHANGES IN EMPLOYEE HEALTH INSURANCE
COVERAGE OVER PAST THREE YEARS
(Excluding firms not in business or without
coverage three years ago)

	HEALTH INSURANCE CHANGES				
COVERAGE	Decrease	No Change	Increase	No Answer	Total
Percent of Employees	5	53	20	22	100%
Benefits	14	39	26	21	100%
Premium Cost (employer's)	4	6	75	16	100%
Premium Cost (employee's)	2	38	27	33	100%
Deductibles	4	35	38	23	100%
Co-Insurance Requirements	1	52	11	36	100%

Number = 828

Costs

It is not news that health insurance premiums are expensive. The average firm purchasing insurance spent approximately $1,750 per month for coverage--more than double the sum spent in 1978 (Table 8). (Health care costs rose 84% over the period). Moreover, health insurance premiums amounted to a substantial portion of the total cost of an employee's benefit package. Compare the data on Table 8 to the data on Table 9. Note that the mean monthly health insurance cost was $1,766 and the estimated mean monthly benefit cost was $2,392. That implies health insurance accounted for nearly 75% (in costs) of total voluntary benefits provided. That comparison can be misleading, however. The potential for deception is best illustrated in the less than $100,000 annual gross receipts classification where the health premiums were larger than the total amount of voluntary benefits. The reason was that the total benefit figure was based on the 938 respondents; the total health premium figure was based on the 794 respondents. Nevertheless, it is clear that health insurance costs constituted a very large share of a small business's employee benefits package no matter how it is measured.

Table 10 places these health insurance cost figures in a more understandable form. The median (50% above-50% below) small employer cost of insurance per employee lay between $75 and $99 per month. However, the average was drawn higher due to the nearly 20% absorbing a monthly cost of $150 or more. The median cost per employee with dependent coverage amounted to somewhat more than $125.

Part of the reason small employers faced such large health insurance costs was that more than 2/3 paid the entire premium, and a whopping 87% paid more than half (Table 11). (Both figures cited adjust for the 10% no answer). Curiously, 72% of those with insurance and annually grossing $100,000-$199,999 picked up 100% of the premium (over 80% adjusting for no answer). The figure fell into the 60's among those firms grossing $200,000 to $4,999,999, then into the 40's among firms grossing more than $5,000,000. This somewhat surprising distribution may be the result of administrative costs and bother in deducting the employee's share when few employees are affected; wages can be adjusted more easily. It also might reflect an emulation by small businesses with greater than 50 employees of large and medium sized enterprises where the trend has been toward a reduced employer share.

Table 8

MEAN MONTHLY EMPLOYER HEALTH INSURANCE PREMIUMS COSTS BY SMALL BUSINESS BY ANNUAL GROSS RECEIPTS AND SMALL BUSINESS INDUSTRY - 1978 and 1985

1978 ANNUAL GROSS ($000's)	1978 Mean Monthly Premium	1985 Mean Monthly Premium	1985 ANNUAL GROSS ($000's)
Under 50	$ 167	$ 460	Under 100
50-99	$ 168	$ 383	100-199
100-199	$ 327	$ 718	200-499
200-349	$ 396	$ 974	500-799
350-799	$ 558	$1,137	800-1,499
800-1,499	$ 958	$2,435	1,500-2,999
1,500 or More	$2,268	$3,134	3,000-4,999
		$4,871	5,000-9,999
		NA	10,000 or More
ALL FIRMS	$ 838	$1,766	ALL FIRMS

INDUSTRY	1978 Mean Premium	1985 Mean Premium	Percent Change 1978 to 1985
Construction	$ 868	$1,492	72%
Manufacturing	$1,805	$3,552	97%
Transportation	$ 538	$1,624	202%
Wholesale	$ 833	$1,898	128%
Retail	$ 504	$1,090	116%
Agriculture	$ 677	$1,426	111%
Financial Service	$ 836	$1,346	61%
Services	$ 541	$1,469	172%
Professional Service	$ 451	$1,445	200%
ALL FIRMS	$ 838	$1,766	111%

NA A few relatively large businesses reported health insurance premiums that were considerably "out of range." Treatment of these data is outlined in Table 9.

Table 9

ESTIMATED MEAN EMPLOYER COST OF VOLUNTARY BENEFITS AND HEALTH INSURANCE BY SMALL BUSINESS ANNUAL GROSS RECEIPTS

ANNUAL GROSS RECEIPTS ($000's)	Mean Monthly Cost of Voluntary Benefits	Number	Mean Monthly Cost of Health Insurance	Number	Per Firm Health Insurance As A % of All Voluntary Benefits[1]	Population Health Insurance As A % of All Voluntary Benefits[2]
Under 100	$ 348	64	$ 460	30	132%	62%
100-199	$ 701	110	$ 383	78	55%	39%
200-499	$1,074	190	$ 718	154	67%	34%
500-799	$1,469	128	$ 974	107	66%	55%
800-1,499	$2,081	144	$1,137	148	55%	---
1,500-2,999	$3,748	120	$2,435	117	65%	63%
3,000-4,999	$4,397	60	$3,134	55	71%	65%
5,000-9,999	$6,291	48	$4,871	40	77%	64%
10,000 or More	NA	47	NA	40	---	---
No Answer	$2,707	27	$2,080	25	77%	71%
ALL FIRMS	$2,392	938	$1,766	794	74%	63%

[1] Calculated by dividing the mean monthly cost of health insurance by the mean monthly cost of voluntary benefits.

[2] Calculated by dividing the sum of health insurance costs in each size class (not shown) by the number in each size class reporting a voluntary benefits cost. The result was divided by the mean monthly employer cost of voluntary benefits.

NA A few large small businesses reported both voluntary and compulsory benefit levels that were considerably "out-of-range." While there is no question of the data's authenticity, additional work is required before they can be reported. Until then, the maximum allowable cost for purposes of calculating an all firms average is $9,999 per month.

Table 10

PERCENTAGE DISTRIBUTION OF EMPLOYERS' COSTS IN PROVIDING HEALTH INSURANCE FOR INDIVIDUAL EMPLOYEES AND DEPENDENTS

	Individual Employee			Employee and Dependents	
EMPLOYER'S SHARE OF MONTHLY PREMIUM PER EMPLOYEE	Total	Total-N/A Excluded	EMPLOYER'S SHARE OF MONTHLY PREMIUM PER EMPLOYEE	Total	Total-N/A Excluded
$ 0-9	1	2	$ 0-24	9	11
$ 10-24	2	3	$ 25-49	3	4
$ 25-49	10	13	$ 50-74	8	10
$ 50-74	20	26	$ 75-99	7	9
$ 75-99	16	20	$100-124	10	13
$100-124	8	11	$125-174	17	23
$125-149	5	6	$175-224	12	15
$150 or more	15	19	$225 or more	11	14
No Answer	23	--	No Answer	23	--
TOTAL	100%	100%	TOTAL	100%	100%
Number of Resp.	992	713	Number of Resp.	922	706

Table 11

ANNUAL GROSS RECEIPTS OF SMALL BUSINESSES PROVIDING EMPLOYEE HEALTH INSURANCE BY EMPLOYEE SHARE OF HEALTH INSURANCE PREMIUM (in percent)

	EMPLOYEE PREMIUM SHARE							
ANNUAL GROSS RECEIPTS ($000's)	None	1-24%	25-49%	50-74%	75-99%	100%	No Answer	Total
Under 100	63	9	6	6	*	*	17	100%
100-199	72	8	4	2	1	1	11	100%
200-499	62	5	8	10	*	2	13	100%
500-799	64	8	9	3	1	3	11	100%
800-1,499	62	9	10	8	1	1	8	100%
1,500-2,999	67	9	7	10	2	1	5	100%
3,000-4,999	63	9	8	9	2	2	8	100%
5,000-9,999	44	10	20	14	*	*	12	100%
10,000 or More	44	12	14	18	*	2	10	100%
No Answer	46	12	15	6	*	3	18	100%
Percent of Resp.	62%	8%	9%	9%	1%	1%	11%	100%
Number of Resp.	567	76	83	78	7	13	98	922

* less than 0.5%

Carriers and Sponsors

A majority (53%) of small business owners carried their health insurance with a private carrier other than Blue Cross/Blue Shield (Table 12). From the comparatively few respondents specifying one of these carriers, the Travelers appeared to serve the largest number. The "Blues" carried 24%. Self-insurance (4%) and HMO's (3%) remained an oddity. Sixteen (16) percent did not respond. With the exception of self-insurance, which naturally was confined to those with $5 million or more in annual gross receipts, the carrier seemed unrelated to either industry or firm size.

The firm itself was the most frequent group sponsor (45%), followed by trade or business associations (27%) (Table 12). But among some industries, there was a far greater propensity to have association-sponsored plans than among others. For example, owners of professional service and financial service firms procured their employee health insurance through trade associations with twice the frequency as did owners of manufacturing and agricultural firms (Table 13). No immediate explanation for these differences was apparent. The most obvious, firm size which was directly related to industry, showed no relationship to group sponsor. The comparative strength or marketing capacity of varying trade groups may provide the answer, but the survey did not collect information regarding association membership.

Table 13 provides evidence of a major shift in group sponsors over the past seven years. The trade association has been increasing in importance at the direct expense of the individual firm. In fact, proportionately distributing no answers, as was done on Table 13, the net increase in firms providing health insurance was almost identical to the net increase in the number of firms with an association sponsor. But the results were mixed when assessing whether or not the trend toward trade associations as sponsors has been a factor in increasing insurance coverage in those industries principally responsible for the overall small business increase. Recall that it was growth in the financial services, professional services, and retail as well as smaller firms that were largely responsible for the increase in the number of firms covered between 1978 and 1985. Neither the retail nor the financial services industries shifted group sponsorship to to the degree the total population did. Professional services, however, showed the most radical shift to association sponsorship (19 percentage points). Unfortunately, a comparison with 1978 could not be made since that data could not be recaptured. Another piece of data -- the reduced incidence of smaller firms citing an inability to obtain group insurance -- also suggests that trade associations may have been helpful to the smallest firms.

Table 12

INSURANCE CARRIER OF SMALL BUSINESSES PROVIDING EMPLOYEE HEALTH INSURANCE BY GROUP SPONSOR
(in percent)

	GROUP SPONSOR					
INSURANCE CARRIER	Firm	Trade Assoc.	Self-Insured	Other	No Answer	Total
HMO	4	2	3	*	2	3%
Self-Insured	1	4	46	*	2	4%
Blue Cross/ Blue Shield	31	26	14	9	12	24%
Other Private	60	65	37	87	24	53%
No Answer	4	4	*	4	61	16%
Total	100%	100%	100%	100%	100%	100%
Number of Resp.	414	251	35	23	199	922

* less than 0.5%

Table 13

PERCENTAGE DISTRIBUTION AND CHANGE IN DISTRIBUTION OF GROUP SPONSORING SMALL BUSINESS EMPLOYEE HEALTH INSURANCE - 1978 AND 1985

	YEAR		PERCENT CHANGE
GROUP SPONSOR	1978*	1985@	1978-1985
Firm	70	57	-19
Trade Association	25	35	+40
Construction	(23)	(36)	(+57)
Manufacturing	(11)	(21)	(+91)
Transportation	(33)	(37)	(+12)
Wholesale	(24)	(40)	(+67)
Retail	(33)	(36)	(+ 9)
Agriculture	(19)	(25)	(+32)
Financial Services	(43)	(47)	(+ 9)
Services	(29)	(30)	(+ 3)
Professional Services	(33)	(52)	(+58)
Other	5	8	+60
TOTAL	100%	100%	--

* estimated from data in 1978 report
@ distributing a 22% no response
() subtotals

Satisfaction With Insurance

Almost 2/3 (66%) of the small employers providing at least some health insurance coverage were generally satisfied with the plan made available to their employees (Table 14). While at first blush a 66% satisfaction rating would seem favorable, it was 16 percentage points lower than the 1978 evaluation. The change from 1978 should not be surprising given the very large increases in premiums paid (see Table 9). Note, for example, that the percent indicating "not satisfied, but can't afford a better plan" rose seven percentage points over the period. In addition, Table 15 shows that those with less costly plans were more often satisfied than were those with more expensive plans.

Satisfaction appeared unrelated to either the plan carrier or the group sponsor. But as expected, satisfaction was related to the amount of time spent investigating health insurance options, health care cost reduction alternatives, etc. The more dissatisfied the small business owner was with his insurance, the more time he spent looking for alternatives. However, a variety of factors intervened to reduce the strength of the satisfaction/search relationship.

Table 14

PERCENTAGE DISTRIBUTION OF SMALL BUSINESS OWNER SATISFACTION WITH EMPLOYEE HEALTH INSURANCE - 1978 AND 1985

SATISFACTION	YEAR	
	1978	1985
Generally Satisfied	82	66
Not Satisfied, Can't Afford Better	9	16
Not Satisfied, Soon Will Have Better	2	3
Soon Will Reduce Coverage	*	1
Soon Will Drop Coverage	N/A	*
Subject to Union Agreement	3	2
No Answer	4	11
TOTAL	100%	100%

* less than 0.5%
N/A not asked

Table 15

SMALL BUSINESS OWNER SATISFACTION WITH EMPLOYEE HEALTH INSURANCE PLAN BY EMPLOYER'S COST
(in percent)

	EMPLOYER'S COST PER INDIVIDUAL ($'s)					
SATISFACTION	Less Than 50	50-99	100-149	150 or More	No Answer	Total
Generally Satisfied	78	76	66	65	44	66%
Not Satisfied, Can't Afford Better	19	16	21	18	11	16%
All Others	2	5	7	15	6	6%
No Answer	*	4	6	2	39	11%
Total	100%	100%	100%	100%	100%	100%
Number of Respondents	127	330	122	134	209	922

* less than 0.5%

Searching for Health Care

Small business owners are busy people; their time is often their greatest asset. Thus, it should not be startling that few small business owners personally spent much time searching for health insurance options, means to control health care costs, etc. But it is startling that neither they nor a designated employee spent much time considering options to the rapidly escalating cost of health insurance and health care.

The median time spent (owner or designated employee) investigating health care options within the last 12 months was about four hours or one-half day (Table 16). Clearly, those that had coverage spent more time than those who did not, but not by the margin one might have expected. Moreover, those covering a greater proportion of full-time employees did not spend appreciably more time than did those covering a lesser proportion.

The most noticeable cell on Table 16 is the one indicating that 41% of those without insurance spent less than one hour within the last year looking at health care options. This group probably consisted for the most part of those not interested in locating coverage. But, there were also many who spent a reasonable time searching and simply could not find something to meet their needs.

The amount of time spent searching was clearly reduced by the dependence on outside advisors. In the overwhelming majority of instances (over 60%), small business owners relied on outside professionals to provide them information on health insurance and health care costs, options, etc. The single most important source of that information, and by overwhelming margins, was the insurance agent. Forty-four (44) percent of all respondents cited this source, followed by trade associations (16%), insurance brokers (15%), magazines/publications (4%), health care providers (2%), business consultants (2%), and other (1%); 16% did not respond (Table 17). Curiously, the amount of owner/employee time spent searching increased with reliance on brokers and consultants, but decreased with reliance on agents. The opposite would have been expected. Brokers and consultants effectively become employees when engaged for certain purposes; their incentive is to reduce client costs. The incentive for agents is somewhat different.

Table 16

SMALL BUSINESS OWNER OR EMPLOYEE HOURS SPENT INVESTIGATING HEALTH CARE OPTIONS IN LAST 12 MONTHS BY PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM
(in percent)

	PERCENT OF FULL TIME EMPLOYEES COVERED IN EACH FIRM					
HOURS SPENT IN LAST 12 MONTHS INVESTIGATING	None+	1-39%	40-60%	61-99%	100%	Total
Less Than One	41	28	24	13	19	27%
1-4	14	19	18	20	20	18%
5-8	9	16	15	18	14	13%
9-16	5	13	12	17	13	11%
17-24	2	3	5	4	7	4%
25-40	3	6	11	11	8	7%
41-80	1	4	5	7	6	4%
81 or More	*	2	*	1	5	3%
No Answer	25	11	11	9	6	14%
Total	100%	100%	100%	100%	100%	100%
Number of Resp.	517	110	66	149	597	1439

* less than 0.5%
+ includes no answer

Table 17

MOST IMPORTANT HEALTH COST INFORMATION SOURCE FOR SMALL BUSINESS OWNERS BY HOURS SPENT INVESTIGATING HEALTH CARE OPTIONS IN LAST 12 MONTHS

(in percent)

MOST IMPORTANT INFORMATION SOURCE	HOURS SPENT INVESTIGATING IN LAST 12 MONTHS						
	Less Than One	1-4	5-8	9-16	17 or More	No Answer	Total
Insurance Agent	51	55	54	47	42	10	44%
Insurance Broker	7	15	19	24	30	3	15%
Trade Association	18	21	15	16	16	4	16%
Health Care Providers	3	1	4	1	2	2	2%
Magazines/ Publications	5	4	3	4	4	1	4%
Business Consultant	1	*	2	3	4	1	2%
Other	2	*	*	1	1	*	1%
No Answer	13	3	2	4	1	80	16%
Total	100%	100%	100%	100%	100%	100%	100%
Number of Resp.	395	256	184	152	255	197	1439

* less than 0.5%

Minimum Coverage Requirements

At least 20 states now require that any business providing employee health insurance include minimum levels of coverage for particular health conditions. For example, Massachusetts mandates that employer-based health insurance include certain levels of mental health coverage. While still reasonably new, a question arises on the impact or influence of such public policy given that economic causes are frequently cited for non-coverage.

Table 18 illustrates that comparatively few small employers recognized that minimum coverage requirements exist. Just 6% reported their state had such requirement; 26% didn't know if their state did or not. Grouping the states with minimum coverage and those without, then distributing the small business population among them, the percent recognizing the requirement was only a fraction of those to which it applied and for which they were paying. The reason so few recognized those minimum coverage requirements is obvious. The additional coverage is wrapped in the new policy and given to the small business owner on a "take it or leave it" basis.

Of the 6% recognizing minimum coverage requirements, two of three indicated they did not change coverage in response. The next largest group expanded coverage to comply, with only a smattering claiming to have either shifted or dropped coverage. But the sample numbers are far too small to make any generalizations.

Table 18

PERCENTAGE DISTRIBUTION OF SMALL BUSINESS OWNER AWARENESS OF AND CONSCIOUS RESPONSES TO STATE MINIMUM COVERAGE REQUIREMENTS

MINIMUM CHANGE REQUIREMENTS	AWARENESS OF REQUIREMENTS	CONSCIOUS RESPONSES
Yes	6	
No Change in Coverage		66
Coverage expanded		22
Shifted Coverage		4
Dropped All Coverage		1
Doesn't Affect Me		1
No Answer		6
Subtotal		100%
No	68	
Don't Know	26	
TOTAL	100%	

Non-Coverage

Despite the increased number of small business owners providing employee health insurance, over one-third provided none; others did not provide it for all employees. The reason(s) for pursuing the no insurance option were neither surprising nor irrational. While no single reason dominated, almost all fell under the general headings of work force composition or cost.

"Generally covered under a spouse or parent policy" was the single most frequently given reason (29%) (Table 19). In other words, the employee mix consisted of significant proportions of secondary wage earners. Covering this group presumably increases labor costs without providing any additional benefits to employees. Table 19 reveals that the secondary wage earner issue was the primary reason firms with coverage often did not include all employees in the benefit. "Employee turnover too great," a second labor force composition reason, was more frequently cited by larger employers (Table 20). Recall that in the previous discussion of benefit conditions, employee tenure was the most frequently used method to separate eligibility for health insurance benefits where such separation existed (Table 4).

It was often a simple matter of economics for employers who provide no health insurance. Half of those without insurance either attributed their action to premiums being too high (33%) or to insufficient profitability (20%)--opposite sides of the same proposition. Not surprisingly, these economic reasons were most pronounced among those with coverage for no full-time employees.

Another 19% said the firm could not qualify for group coverage, which implies another variant of the cost problem. The inability to qualify as a group (real or perceived) was focused among the respondents employing 1-4 people (Table 21). Sixteen (16) percent of the very smallest employers cited it. Moreover, almost all who believed they could not qualify for group coverage indicated the reason was business size.

Despite additional response categories in the 1985 survey, the distribution of reasons for not having employee health insurance in 1985 was similar to distribution in 1978. The two reasons most frequently cited in 1978 were the two most frequently cited in the current survey. A nuance in this regard was that those attributing their action to a predominance of secondary wage earners fell twelve percentage points to 26%. There is no immediate explanation for the fall. Small declines were also registered for employee turnovers and can't qualify for a group.

Given the reasons for not currently providing employee health insurance, stimulants to provide it were predictable. Lower rates and greater profitability were the two most frequently noted (Table 21). "Business got bigger," "qualify as a group," and "employees asked for it" followed at a distance. Just 4% of those not providing coverage for all full-time employees, or 3% of the entire sample, indicated they would not provide health insurance under almost any circumstance. That is about the same as the number providing the identical response in 1978.

Table 19

SMALL BUSINESS OWNER REASONS NOT TO PROVIDE HEALTH INSURANCE TO ALL FULL-TIME EMPLOYEES BY PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM (in percent)

	PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM				
REASON	None+	1-39%	40-60%	61-99%	Total
Premiums Too High	33	29	14	7	27%
Employee Turnover Too Great	15	21	18	8	15%
Generally Covered Under A Spouse or Parent Policy	26	29	33	26	29%
Never Thought About It	2	*	*	*	1%
Administrative Expenses Too High	8	5	2	1	6%
Employees Prefer Compensation	8	10	6	5	8%
Firm Insufficiently Profitable	20	10	11	2	15%
Can't Qualify For Group Policy	19	4	2	2	12%
Other	4	7	*	4	4%
Total@	135%	115%	86%	55%	117%
Number of Respondents	517	110	66	149	842

+ includes no answer
* less than 0.5%
@ respondents could mark more than one answer

Table 20

SMALL BUSINESS OWNER REASONS NOT TO PROVIDE HEALTH INSURANCE TO ALL FULL-TIME EMPLOYEES BY FIRM SIZE

(in percent)

	FIRM SIZE (FULL-TIME EMPLOYEES)						
REASON	1-4	5-9	10-19	20-49	50+	No Answer	Total@
Premiums Too High	32	32	30	21	11	14	27%
Employee Turnover Too Great	16	16	15	24	26	7	15%
Generally Covered Under A Spouse or Parent's Policy	33	32	40	23	14	11	29%
Never Thought About It	2	*	*	*	*	2	1%
Administrative Expenses Too High	7	6	5	3	6	4	6%
Employees Prefer Compensation	7	10	10	9	6	4	8%
Firm Insufficiently Profitable	20	12	9	6	9	13	15%
Can't Qualify For Group Policy	16	5	6	2	*	18	12%
Other	2	1	3	9	11	10	4%
Total@	135%	114%	118%	97%	83%	83%	117%
Number of Respondents	365	146	97	66	35	133	842

* less than 0.5%

@ respondents could mark more than one answer

Table 21

CAUSES FOR SMALL BUSINESS OWNERS TO PURCHASE HEALTH INSURANCE FOR ALL FULL-TIME EMPLOYEES BY PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM
(in percent)

	PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM				
CAUSE TO PURCHASE	None+	1-39%	40-60%	61-99%	Total@
Qualify as a Group	16	5	*	3	11%
Business Became More Profitable	24	23	11	4	23%
Rates Were Lower	36	23	17	9	28%
Minimum Coverage Requirements Dropped	5	5	2	1	4%
Rates and Coverages More Stable	8	5	3	2	6%
Business Got Bigger	19	11	6	3	14%
More Difficult to Find Good Employees	6	6	6	3	6%
Employees Asked For It	10	15	3	8	9%
Wouldn't Provide Under Almost Any Circumstance	5	3	2	1	4%
Total@	129%	96%	50%	34%	105%
Number of Respondents	690	105	32	44	871

+ includes no answer
* less than 0.5%
@ respondents could mark more than one answer

Concluding Observations

The survey did not (and probably could not) obtain data on the level of health insurance benefits provided. However, the evidence available suggests that benefits are surprisingly consistent or uniform given the varying conditions of the small businesses and small business owners surveyed. For example, almost all providing insurance carried hospitalization/surgical and major medical; virtually none provided lesser degrees. Similarly, virtually all had a dependent care option. While a broad distribution of monthly per employee costs was apparent, arguing against a uniformity thesis ("you get what you pay for"), the principal distinction seemed to occur between those employees covered and those employees not covered. Recall that no employees were offered health insurance in 36% of the firms and only selected employees were offered health insurance in 23% of firms. Given those conditions and the economic reasons many small employers gave for not offering health insurance, it is curious that the distribution of benefits is not much greater than it appears. This situation raises two related points. The first is whether the employer's decision to provide "all or nothing" coverage is purposeful or whether insurance pricing is structured to force a decision. The second is that public policy actions to include minimum coverage requirements serve to increase the gap between those covered and those not covered.

The dependence on outside advisors for health-related matters appears unusually high given the costs involved. Assuming these appearances are not deceiving, an entire series of questions then arise. For example, why is more responsibility delegated on health care to an "outsider" than it probably is on other purchasing decisions? Is it to the owner's and/or employees' benefit? What effect does it have on coverage patterns? This survey was not intended to answer such questions, but they are important ones that need to be addressed at some point.

There is no reason to expect a significant increase in the number of firms providing employee health insurance such as the one experienced between 1978 and 1985. However, some rise might be expected. On the plus side, reductions in health care cost increases should translate into more reasonable insurance costs (though they still are rising faster than inflation). A second plus is that trade associations show every sign of maintaining, if not increasing, their insurance-related activities. Association activity should continue to provide smaller and often less affluent firms access to group coverage. The third factor is that health insurance is increasingly accepted as a condition of employment; the market from this perspective is pushing greater direct coverage. But on the negative side, small business profitability was high in 1978 and reasonably high in 1985 (it peaked about a year and one-half earlier). It is doubtful similar favorable economic conditions can stimulate much broader coverage. Poorer conditions could do the opposite. In addition, there will always be differences in profitability, meaning there will always some firms with an affordability problem. Those negative reasons are on top of the employee related causes for not providing insurance. With the increasing use of part-time labor and secondary wage earners, the incentive to provide health insurance is declining; the market from this perspective is promoting less direct coverage. Thus, there are cross-currents which will influence small business owners' decisions on health care. On balance, these factors point to greater coverage, but not much greater.

POLICY RECOMMENDATIONS AND CONCERNS

General

Based on the foregoing information and on our policy polls (Appendix A), the National Federation of Independent Business is opposed to any program of compulsory national health insurance, including one covering catastrophic illness only. The vast majority of Americans are protected by voluntary private insurance programs or existing government programs. Furthermore, an increasing percentage of American firms are voluntarily providing substantial health insurance benefits to their employees. The need for such an intrusive policy on the part of the federal government seems to be minimal; indeed, this seems to have been generally accepted lately, since the public policy debate is no longer focused on broad mandatory national requirements but rather on trying to address the specific problems of limited portions of the population, e.g., those with existing medical problems, self-employed, children, unemployed persons, and others desirous of being insured but unable to afford it. This has been a generally positive turn of events and one which NFIB finds encouraging. However, in the attempt to target policy to such groups, Congress and the states must be careful not to create new gaps by discouraging (because of mandated cost increases or unrealistic administrative demands) the increase in voluntary employer sponsorship of health plans. In short, we are happy to assist this committee, or anyone else, with information about the characteristics of small firms in this country which might assist in a market-oriented solution to closing the health insurance coverage gap.

While an increasing percentage of small business owners provide employee health insurance, it would be unrealistic to expect, and unwise in the extreme to mandate, 100% coverage of all small business employees in the country. There are too many factors which neither the government nor the small business owner can control which mitigate against such an expectation or such a mandate. Such things as high employee turnover, the large percentage of secondary wage earners working for small businesses, and the variable profitability of firms are all beyond the control of reasonable policy. Nevertheless, some of the reasons currently given for non-coverage may be amenable to policy changes. That the firm can't qualify for a group policy or that premiums are too high may bear investigation. Let me first consider the limiting conditions.

Employee turnover in small businesses is high, although layoffs appear relatively low except in the construction industry. This is the result of numerous factors, including heavy utilization of teenagers, seasonal help, generally lower wage scales, etc. In fact, the NFIB Quarterly Economic Report for Small Business consistently finds approximately one in ten small firms has a net decrease in employment every quarter, with an average of three to four employees per firm. While these data do not capture the extent of turnover because they measure only decreases among firms registering net decreases in total employment, they are indicative of the situation. Corroborative indications of high employee turnover can be found in two additional pieces of data: 1) 38% of all small employers register as a common complaint about job applicants that they will not stay long; and 2) 15% of those small firms not carrying employee health insurance indicate high employee turnover as a reason for not doing so.

Secondary wage earners are a very large portion of the small business labor force. NFIB estimates that 80% of all teenagers working are now employed by small firms. While all teenagers are not secondary wage earners, they are far more frequently secondary wage earners than adults. In all size categories of businesses, the single biggest reason for not providing health insurance to all employees was that their employee mix consisted of significant numbers of people generally covered under a spouse's or parent's policy.

Profitability is a problem for every business entity, but particularly so for the very smallest firms, which are often start-ups. There are large numbers of marginal small businesses that simply cannot afford to increase fixed costs by offering health insurance benefits to employees. We find that the median money-income of self-employed persons is lower than the median money income for the population as a whole. The assumption, therefore, that all firms are capable of taking on such an additional fixed cost simply isn't valid. Looking back to tables 2 and 20, in the size categories 1 to 4 and 5 to 9, I believe demonstrates this point quite vividly. It is in these size categories where lack of profitability is a significant reason for not offering health insurance, and they are also where we see the largest gap in coverage.

The above three factors taken together must obviously limit one's expectations about the ability of small firms to provide health insurance for employees. They also are limitations to federal or state policy in this area. The following are some of those policy limits:

> First, a period of employer-paid insurance benefits beyond job termination is unreasonable. It is conceivable, under some of the proposals I have seen, that a small employer could pay for an employee's insurance for more than twice the number of days that individual was employed (e.g., assume insurance eligibility after one month's employment and coverage termination three months after separation). This situation opens the door to all kinds of abuse and serves as an incentive for movement in and out of the labor force. More importantly, however, it would generate considerable paperwork and unnecessary premium payments. For example, if a separated employee immediately accepted another job unbeknownst to the original employer, both employers could be paying premiums on the same individual. Furthermore, those employers without computerized payroll systems, i.e. most small employers, would find themselves filing and re-filing with their insurance companies as well as rearranging their bookkeeping procedures to ensure that a separated employee is removed from the covered list as soon as legal.
>
> Second, any program that required coverage for seasonal employees -- those that are hired for a specified period of time, like the Christmas season or for the summer -- would be a mistake. In such short-term employment situations, it is recognized by both parties that the employment is temporary and not necessarily

subject to the identical pay or benefit conditions of those employed full time. If such employees were required to be covered by statute, the incentive would be for employers to reduce the number of jobs for teenagers, particularly by having existing employees work overtime, or by developing some "three weeks working and one week not working" mechanism to avoid the system, or by doing without -- none of which would be beneficial to the employees or the employers.

Third, unless consideration is given to the problem of double coverage (beyond that already cited) resulting from the large proportion of secondary wage earners in the small business labor force, any nationally-mandated program would be terribly wasteful and unnecessarily expensive. For example, a small employer could be required to pay for insurance on a teenage employee while that teenager's father's employer could also be paying premiums for that teenager. To further illustrate this point, the following example is provided*:

Small businessman Jones owns and operates a nursery. Mr. Smith works for Mr. Jones and is covered by health insurance. During the spring and summer, business always picks up, so Mr. Jones hires four teenagers, including Mr. Smith's two sons. Two of the teenagers begin work May 15, and the Smith boys start June 1 and June 7. On June 15, small businessman Jones begins to pay insurance premiums on the first two teenagers hired (neither they nor Mr. Jones knows they are already covered under their parent's plans), but on June 20 one of them quits, to be followed by the second four days later. Two more teenagers (also unknowingly covered by their parent's plans) are hired June 25 and July 4th. The Smith boys leave the job to return to school on August 24 and September 1. The other teenagers leave September 14th, but one of the two drops out of school in a week and takes a full time job. Here is the result of summer employment for small businessman Jones:

--about 15 months of work
--nearly 30 months premiums paid
--no additional coverage secured for any employee
--considerable paperwork

Cost are not estimated here because it makes a considerable difference whether or not Mr. Jones's business is large enough to qualify as a group. This brings me to the problems cited by small business owners which originate from the product, or seller's, side of the market.

---

* This example assumes required coverage one month after employment through three months after job determination.

The two biggest reasons cited by small employers for non-coverage in this regard were that premiums are too high (overall this was the second most important reason for non-coverage) and that the firm could not qualify for a group policy. The one thing most often cited by small firms, especially the smallest, that would induce them to offer health insurance for all their full-time employees was lower premium rates. It should be noted our data show that small businesses in the aggregate have had their premium costs doubled in the last eight years. In some industries, like transportation and the professional services, these costs have tripled in the last eight years. Part of the reason small employers face such large health insurance costs is that more than two-thirds of them paid the entire premium cost for their employees, and 87% of them paid more than half. In addition, it is the smaller firms which pay a greater proportion of the premiums themselves.

The point for policy makers here is, however, that if they wish to increase the percentage of small business employees who are voluntary covered by health insurance plans, they should look to the health care industry and the insurance industry to ensure that the market is operating to provide the lowest prices. That is, to insure the market is operating efficiently and competitively. Not being an expert in either the health care industry or the insurance industry and having no policy guidance in this regard from my members, we will leave that judgment to others for the moment. We will note only that the cost of insurance, all types of insurance, has emerged as the number one problem of small businesses in this country.

The percentage of small employers that do not have any employee health insurance and who claim that they do not do so because they cannot qualify as a group has declined since 1978 from 25% to 12% in the aggregate. We attribute this drop to the fact that trade associations are increasingly acting as group sponsors. NFIB, for example, has recently became a group sponsor offering employee benefit packages to our members. While we expect this trend to continue and to improve the coverage problem, it is perhaps another area for policymakers to investigate. It may be feasible for the government to operate as a market maker in this area. While the inability to qualify as a group has declined, it still remains one of the major barriers to offering health insurance plans for small employers. NFIB is not advocating government involvement in this area, since we expect trade associations to increase their activities in offering group plans. It is, however, an aspect of the overall problem which may more easily lend itself to government involvement than would other aspects of the problem.

APPENDIX A

MANDATE QUESTIONS ON HEALTH INSURANCE

DESCRIPTION	MANDATE #	DATE	FOR	AGAINST	UNDECIDED
Do you favor a mandatory national health insurance program? a) yes; b) yes, but catastrophic only; c) no; d) undecided?	400 (1)	12/76	a) 10% d) 3%	b) 34%	c)53%
If everyone were covered by a system of mandatory national health insurance, what benefits should be available? a) comprehensive; b) deductible; c) catastrophic only; d) undecided?	400 (2)	12/76	a) 6% d) 8%	b) 19%	c)67%
If a system of mandatory national health insurance were established, how should it be financed? a) general taxes; b) payroll deductions; c) premiums; d) undecided?	400 (3)	12/76	a) 24% d) 12%	b) 14%	c)50%
If a system of mandatory national health insurance were established, who should administer it? a) federal government; b) state government; c) private insurance companies; d) undecided?	400 (4)	12/76	a) 10% d) 12%	b) 10%	c)68%
Should employers be required to provide a minimum level of private health insurance for their employees? a) yes, and pay the entire premium; b) yes, and pay part of the premium; c) no; d) undecided?	400 (5)	12/76	a) 4% d) 5%	b) 19%	c)72%
A program of national health insurance to cover catastrophic illness only?	415 (3)	1/79	39%	55%	6%
The Medical Expense Protection Act?	426 (4)	4/80	14%	79%	7%

DESCRIPTION	MANDATE #	DATE	FOR	AGAINST	UNDECIDED
Taxing--as income to employees--employer-paid health-insurance premiums in excess of $175 per family, per month?	448 (2)	4/83	25%	72%	3%
Limiting the deductions for health insurance for employers?	451 (2)	11/83	26%	69%	5%
Taxing employees on fringe benefits?	459 (2)	4/85	24%	72%	2%
Allowing states to require certain types of coverage in employer-sponsored health plans?	462 (4)	12/85	9%	89%	2%

APPENDIX B

SURVEY SAMPLE

The preceding report was based on data gathered from a mail survey of small business owners conducted in September, 1985. The survey sample was randomly drawn from the membership file of the National Federation of Independent Business (NFIB). All regular members in the file were eligible for selection, the exception being a comparatively small percentage who had no full-time employees. Thus, the resulting sample consisted entirely of small employers. Each of the 7,750 small business owners in the sample received a questionnaire (a copy provided in Questionnaire, p. 46) and a follow-up two weeks later. There were 1,439 usable responses for a 19% response rate, 11 percentage points less than NFIB normally experiences in such surveys.

There is little a priori reason to fear a sample bias. Dunkelberg and Scott have demonstrated that the NFIB membership file reasonably reflects the universe as the universe can best be estimated. Moreover, the sample was not contaminated by association activities involving extensive sale or promotion of employee benefit packages. And while response rates of 30%, let alone 19%, never can provide a survey analyst comfort, previous experience in comparing NFIB-collected responses to equivalent data collected by other organizations shows remarkable consistency, particularly within size class. The differences that do exist usually involve "levels" for the entire population resulting from the somewhat larger businesses within the NFIB file.

Tables A and B provide comparisons of the estimated universe, the survey sample, and the survey respondents. (The estimated universe measures were drawn from the Small Business Administration's (SBA) Small Business Data Base as published in the annual The State of Small Business Report.) Note on Table A that the industry-by-industry differences in these data sets are minimal. Survey respondents are somewhat overrepresented among manufacturers and underrepresented among services. In the other major industries, however, differences usually involve only a percentage point or two.

When employee size is substituted for industry in the three set comparison (Table B), the result is not as satisfactory. The profile of survey respondents and the survey sample are virtually identical, with the exception of 1-4 employee class size and "no answer." Distributing the no answers proportionally among all size classes creates a survey respondent profile still somewhat underrepresented in the 1-4 employee class and a percentage point or two overrepresented in the others. That distribution in and of itself should be sufficient to cover all concerns over the response rate. However, the responses of "no answers" and the responses of other size classes to other comparable questions produce an uncommon similarity between the "no answers" and the 1-4 employee size class. Given that similarity and previous experience which indicates the smallest are most likely not to respond to size questions, responses proportionally allocating "no answers" probably do not assign enough to the smallest size class. As a result, the profile of survey respondents and the survey sample is probably even better than the considerable similarity previously shown.

Table A

COMPARISON OF ESTIMATED UNIVERSE, SURVEY SAMPLE, AND SURVEY RESPONSES BY INDUSTRY
(in percent)

INDUSTRY	ESTIMATED UNIVERSE	SURVEY SAMPLE	SURVEY RESPONDENTS
Construction	14	11	12
Manufacturing (includes Mining)	9	13	13
Transportation	4	3	4
Wholesale	10	7	10
Retail	29	27	27
Agriculture	4	5	5
Financial Services	8	7	9
Services	24	24	19
No Answer	--	2	1
Total	100%	100%	100%

While the estimated universe inflates the 1-4 employee size class a percentage point or two by inclusion of some non-employers, there remains a difference between the estimated universe and the sample. Sample small business owners (as well as respondents) have somewhat larger businesses on balance. The estimated universe contains approximately 10 percentage points more firms in the 1-4 employee size class than did the sample on the response. Those 10 percentage points were distributed over other size classes. Thus, population "levels" are unduly influenced, though not greatly, by owners of firms larger than 1-4 employees.

Table B

COMPARISON OF ESTIMATED UNIVERSE, SURVEY SAMPLE, AND SURVEY RESPONSES BY EMPLOYEE SIZE
(in percent)

EMPLOYEE SIZE	ESTIMATED UNIVERSE	SURVEY SAMPLE	SURVEY RESPONDENTS
1-4	57	48	37
5-9	21	21	21
10-19	11	15	15
20-49	7	11	10
50-99	2	3	4
100 or more	2	2	3
No answer	--	1	11
Total	100%	100%	100%

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TESTIMONY OF

FRANCIS R. CARROLL

PRESIDENT

SMALL BUSINESS SERVICE BUREAU, INC.

ON MANDATED HEALTH INSURANCE BENEFITS

PREPARED FOR THE

U.S. SENATE COMMITTEE ON SMALL BUSINESS

MR. CHAIRMAN, I WANT TO THANK YOU FOR THE OPPORTUNITY TO ADDRESS THE COMMITTEE ON THE ISSUE OF GOVERNMENT INVOLVEMENT IN HEALTH INSURANCE COVERAGE. MY NAME IS FRANCIS R. CARROLL AND I AM PRESIDENT OF THE SMALL BUSINESS SERVICE BUREAU, INC. (SBSB), AN ORGANIZATION REPRESENTING OVER 35,000 SMALL BUSINESSES WHICH ARE "MOM AND POP" COMPANIES FROM ACROSS THE COUNTRY. I AM ALSO A MEMBER OF THE ADVISORY COUNCIL TO THE U.S. SENATE SMALL BUSINESS COMMITTEE.

THE NUMBER ONE ISSUE FACING SMALL BUSINESS OWNERS TODAY IS ACCESS TO QUALITY, AFFORDABLE HEALTH CARE FOR THEMSELVES AND THEIR EMPLOYEES. THERE ARE SEVERAL PROPOSALS BEING CONSIDERED BY CONGRESS WHICH WILL DETERMINE THE FUTURE DIRECTION OF THIS COUNTRY'S HEALTH CARE SYSTEM. WE HAVE REACHED A CROSSROAD REGARDING HEALTH CARE POLICY IN AMERICA. CATASTROPHIC HEALTH COVERAGE AND UNIVERSAL ACCESS TO HEALTH CARE SERVICES ARE ISSUES WHICH WILL HAVE A PROFOUND IMPACT ON ALL HEALTH CARE CONSUMERS AND ESPECIALLY THE SMALL BUSINESS COMMUNITY.

FOR NEARLY 20 YEARS NOW, THE SMALL BUSINESS SERVICE BUREAU HAS BEEN ACTIVELY INVOLVED IN HEALTH CARE AND COST CONTAINMENT ISSUES AT THE STATE AND FEDERAL LEVELS OF GOVERNMENT. ADDRESSING THESE CONCERNS POSES A MAJOR CHALLENGE TO THE PUBLIC AND PRIVATE SECTOR. THE GROUNDSWELL OF SUPPORT FOR LEGISLATION IS A CALL FOR CONGRESS AND THE BUSINESS COMMUNITY TO COOPERATE IN DEVELOPING POLICIES WHICH WILL BE AFFORDABLE, EQUITABLE, AND WHICH WILL ENCOURAGE PRIVATE SECTOR PARTICIPATION.

WITH THIS IN MIND, PLEASE CONSIDER THAT IF CONGRESS VOTES TO MANDATE HEALTH INSURANCE BENEFITS FOR SMALL BUSINESSES, THE

EFFECTS ON THE NATION'S ECONOMY CANNOT BE UNDERESTIMATED. I WOULD THEREFORE LIKE TO SUGGEST OPTIONS TO MAKE THESE MANDATES MORE ACCEPTABLE AND AFFORDABLE TO SMALL BUSINESS.

WHILE SMALL BUSINESSES IN AMERICA GENERATE MOST OF THE NEW JOBS IN THE ECONOMY, THEY ARE THE LEAST ABLE TO AFFORD TO OFFER EMPLOYEE BENEFITS. CONSIDERING THAT 80 PERCENT OF AMERICAN PROPRIETORSHIPS HAVE SALES OF LESS THAN $50,000 ANNUALLY, AND PAY AS MUCH AS 200 PERCENT MORE FOR COVERAGE THAN EMPLOYEES OF LARGE COMPANIES, THIS IS NOT SURPRISING. WITH THESE STATISTICS IN MIND, THE CHALLENGE BEFORE US IS TO PROVIDE THE PROTECTION THE OWNERS, OPERATORS AND EMPLOYEES OF SMALL BUSINESSES NEED WITHOUT CRIPPLING THE VITALITY OF THIS IMPORTANT SECTOR OF OUR ECONOMY.

THE WORD "MANDATED" HAS TRADITIONALLY BEEN A RED FLAG FOR SMALL BUSINESS OWNERS. BUT SBSB MEMBERS NOW REALIZE THAT THE TIME HAS COME TO FACE THE HEALTH CARE CRISIS AND RESPOND TO FEDERAL INITIATIVES WITH CONSTRUCTIVE IDEAS INSTEAD OF REACTIONARY CRITICISM.

IF THE CONGRESS MANDATES HEALTH CARE COVERAGE WITHOUT ADDRESSING THE UNDERLYING PROBLEMS OF ACCESSIBILITY AND AFFORDABILITY FOR SMALL BUSINESSES, YOU WILL BE DOING A GRAVE DISSERVICE TO AMERICAN PRIVATE ENTERPRISE AND ALL SMALL "MOM AND POP" AND FAMILY-OWNED BUSINESSES IN YOUR STATE.

IF CONGRESS SHOULD MANDATE A MINIMUM LEVEL OF HEALTH INSURANCE COVERAGE, I WOULD LIKE TO OFFER SOME ALTERNATIVES FOR YOUR CONSIDERATION:

1. IF PASSED, MINIMUM OR CATASTROPHIC HEALTH CARE LEGISLATION SHOULD BE MANDATED FOR EVERYONE, INCLUDING TAX-EXEMPT NONPROFIT ENTITIES, LARGE EMPLOYERS, AND STATE AND MUNICIPAL GOVERNMENTS.
2. MANDATED COVERAGE SHOULD BE DELIVERED THROUGH WELL-RUN, PROVEN AND EFFICIENT MANAGED CARE PLANS, SUCH AS HMOs, AT THE LOCAL AND REGIONAL LEVEL. PRIVATE SECTOR GROUPS WOULD BE ENCOURAGED TO WORK WITHIN THE SYSTEM TO PROVIDE A GOOD MIX OF QUALITY AND COST-EFFECTIVE HEALTH CARE.
3. SMALL BUSINESSES SHOULD BE GIVEN INCENTIVES TO OFFER HEALTH COVERAGE. CONGRESS SHOULD PROVIDE TAX CREDITS TO BUSINESSES THAT DO COMPLY WITH MINIMUM HEALTH COVERAGE LAWS. THIS TAX CREDIT WOULD ENSURE THAT MANDATED HEALTH COSTS WOULD NOT IMPOSE AN ADDITIONAL BURDEN ON SMALL FIRMS IN THEIR FIRST FEW YEARS, A TIME WHEN THEY ARE MOST LIKELY TO FAIL.
4. CONGRESS SHOULD GUARANTEE THAT MEDICAL EXAMINATIONS WILL NOT BE REQUIRED OF PEOPLE SEEKING HEALTH INSURANCE. THE INSURANCE INDUSTRY'S PRACTICE OF OFFERING AFFORDABLE PREMIUMS TO ONLY THE BEST RISKS (CREAM SKIMMING) IS RESPONSIBLE FOR PART OF THE HEALTH INSURANCE CRISIS WE ARE FACING TODAY.
5. THE SELF-EMPLOYED SHOULD BE ALLOWED TO DEDUCT THE FULL AMOUNT OF THEIR HEALTH INSURANCE PREMIUMS. FOR THE FIRST TIME, THE TAX REFORM ACT OF 1986 ALLOWS THEM TO DEDUCT 25 PERCENT.
6. DEDUCTIBLES AND LARGE CO-PAYMENTS ARE ROADBLOCKS TO HEALTH CARE AND, THEREFORE, SHOULD BE DISCOURAGED. MANAGED CARE WITH NOMINAL CO-PAYMENTS SERVE AS AN INCENTIVE FOR COST-EFFICIENT

HEALTH CARE UTILIZATION AND SHOULD BE INCORPORATED IN THE PLANS.

7. THERE SHOULD BE NO LIMIT ON THE NUMBER OF PLANS MADE AVAILABLE TO EMPLOYEES. GREATER CHOICE MEANS GREATER COMPETITION AND BETTER QUALITY AT A LOWER COST.

8. COST CONTAINMENT PROGRAMS NEED TO BE BEEFED UP. SEVENTY PERCENT OF SBSB MEMBERS RESPONDING TO OUR ANNUAL SURVEY SUPPORT INCREASED GOVERNMENT REGULATIONS TO CONTROL HOSPITAL COSTS AND HEALTH INSURANCE PREMIUMS. THESE ARE THE VERY PEOPLE WHO TRADITIONALLY OPPOSE ANY FORM OF MANDATED BENEFITS. THIS REFLECTS THEIR FRUSTRATION WITH THE HEALTH INSURANCE SYSTEM AS IT EXISTS TODAY.

AN ALTERNATIVE WOULD BE TO EXAMINE THE POSITIVE ASPECTS OF THE CATASTROPHIC HEALTH CARE PROPOSALS OF PRESIDENT REAGAN AND DOCTOR BOWEN. PERHAPS THE GOVERNMENT SHOULD CONSIDER EXPANDING CATASTROPHIC COVERAGE TO INCLUDE THE GENERAL POPULATION AND TO BE PAID FOR OUT OF GENERAL REVENUES. THE GOVERNMENT'S ROLE SHOULD BE TO ENSURE ACCESS, AFFORDABILITY AND QUALITY. ONE MECHANISM THAT COULD BE EMPLOYED BY THE GOVERNMENT TO ASSURE THIS WOULD BE TO REVITALIZE THE HEALTH SYSTEMS AGENCIES (HSAs) OR SOMETHING COMPARABLE.

THERE IS ANOTHER SERIOUS PROBLEM FACING SMALL BUSINESS IN AMERICA TODAY. THAT PROBLEM IS THE BIG BUSINESS ATTEMPT TO DECREASE THEIR HMO HEALTH INSURANCE PREMIUMS AND INCREASE HMO PREMIUMS FOR SMALL BUSINESS.

BIG BUSINESS ACTING THROUGH THEIR AGENTS, THE WASHINGTON

BUSINESS GROUP ON HEALTH, HAVE PRESSURED HCFA, THE HEALTH CARE FINANCING ADMINISTRATION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO PROPOSE THE REPEAL OF EXISTING EQUAL CONTRIBUTION REGULATIONS IN SECTION 110.808 OF THE HMO ACT. THE CHANGES ARE UNDER CONSIDERATION BY HCFA NOW.

UNDER THIS PROPOSAL, EMPLOYERS WOULD NO LONGER BE REQUIRED TO CONTRIBUTE THE SAME PER-EMPLOYEE AMOUNT TO FEDERALLY QUALIFIED HMOs AS THEY CONTRIBUTE TO THE MORE TRADITIONAL HEALTH BENEFIT PLANS THEY PROVIDE.

BIG BUSINESS WOULD THEN BE ABLE TO DECREASE THEIR CONTRIBUTIONS AND SHIFT THE COST, THUS INCREASING THE HMOs' PREMIUMS TO SMALL BUSINESS. INCREASED HMO PREMIUMS WOULD ACT AS A DISINCENTIVE TO JOIN AN HMO PLAN, AFFECT GUARANTEED ACCESS TO HMOs AND REDUCE COMPETITION IN THE HEALTH CARE MARKET.

THIS IS A BIG BUSINESS PROPOSAL AND IS BAD PUBLIC POLICY THAT IS INCONSISTENT WITH THE INTENT OF THE U.S. CONGRESS WHEN IT PASSED THE HMO ACT.

THE POLITICAL ATMOSPHERE DURING THE LAST SIX YEARS HAS FAVORED BIG BUSINESS. THE 100th CONGRESS NOW HAS THE OPPORTUNITY TO HELP SMALL BUSINESS. MANY OF THE ISSUES WE HAVE DISCUSSED HERE TODAY ARE PERCEIVED AS ANTI-SMALL BUSINESS. CONGRESS NEEDS TO TAKE A CLOSER LOOK AT THE IMPACT THESE PROPOSALS HAVE ON AMERICA'S ENTREPRENEURS. THIS COMMITTEE CAN PLAY A MAJOR ROLE IN ENSURING THAT AMERICA'S SMALL COMPANIES GET THE FAIR TREATMENT THEY DESERVE. THANK YOU.